

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10824

CERTIFICATE OF DEATH

10816

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. LENGTH OF STAY IN 1b 12-1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Anne Arundel General Hospital		d. STREET ADDRESS Underwood Road	
3. NAME OF DECEASED (Type or print) First Middle Last John Adolph ABEND		4. DATE OF DEATH Month Day Year August 21 1966	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 12, 1903
9. AGE (In years last birthday) 63 yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY own farm	
11. BIRTHPLACE (County & State, or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Adolph Abend		14. MOTHER'S MAIDEN NAME Louisa Schmidt	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. 218-14-3353	
17. INFORMANT Mrs. Anna M. Abend - same as #2 above		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hepatic failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) Cirrhosis of liver DUE TO (c) —			INTERVAL BETWEEN ONSET AND DEATH 1 week 7 years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Anemia, Hypoprotebinaemia, Asites			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 19 Aug, 1966 , to 21 Aug, 1966 , that (I) (we) last saw the deceased alive on 21 Aug 1966 , and that death occurred at 8:15 P.M. from causes and on the date stated above.			
22a. SIGNATURE Charles W. Kinzer		22b. DATE SIGNED 23 Aug 66	
22c. PHYSICIAN'S NAME (Type) Charles W. Kinzer, MD		22d. ADDRESS Edgewater, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 8/24/66	23c. NAME OF CEMETERY OR CREMATORY Glen Haven Cemetery	23d. LOCATION (City or Town) (County) (State) Glen Burnie, A.A. Md.
24. FUNERAL DIRECTOR Beverly E. Hopping		25a. REC'D BY REGISTRAR Beverly E. Hopping	
HOPPING FUNERAL HOME - Annapolis, Md.		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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CERTIFICATE OF DEATH

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10817

1. PLACE OF DEATH a. COUNTY <u>ANNE ARUNDEL</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>A. ARUNDEL</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ANNAPOLIS</u>		c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ANNAPOLIS</u> 02-1
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>ANNAPOLIS NURSING HOME</u>		d. STREET ADDRESS <u>16 N. Linden Ave.</u> <u>BAY RIDGE / ANNAPOLIS</u>	
3. NAME OF DECEASED (Type or print) <u>JAMES WILLIAM BARNES</u>		4. DATE OF DEATH Month <u>8</u> Day <u>13</u> Year <u>1966</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Wh.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-24-86</u>
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CARPENTER</u>		9b. KIND OF BUSINESS OR INDUSTRY <u>Building</u>	9. AGE (In years birthday) yrs. <u>79</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CARPENTER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Building</u>	11. BIRTHPLACE (County & State, or foreign country) <u>MD.</u> <u>GUILFORD (H. Co)</u>
13. FATHER'S NAME <u>JOHN THOMAS BARNES</u>		14. MOTHER'S MAIDEN NAME <u>Rosie Myers</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>ANNAPOLIS NURSING -</u>		Address <u>BAY RIDGE</u> <u>ANNAPOLIS NURSING -</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARCINOMA OF BLADDER</u> DUE TO (b) <u>1810</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <u>1810</u>			INTERVAL BETWEEN ONSET AND DEATH <u>18 mos</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>8-6</u> , 19 <u>65</u> to <u>8-13</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>8-10</u> , 19 <u>66</u> , and that death occurred at <u>8 P</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>Edward S. Beck</u>		22b. DATE SIGNED <u>8-13-66</u>	
22c. PHYSICIAN'S NAME (Type) <u>EDWARD S. BECK</u>		22d. ADDRESS <u>FRANKLIN ST.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>8-16-66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>ASBURY</u>	23d. LOCATION (City or Town) (County) (State) <u>ARNOLD H.H. MD.</u>
24. FUNERAL DIRECTOR <u>John M. Laylat Sons</u>		25a. REC'D BY REGISTRAR DATE <u>AUG 15 1966</u>	
		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND 10826 CERTIFICATE OF DEATH 10818									
1. PLACE OF DEATH a. COUNTY <u>AA.</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BROOKLYN Park</u> c. LENGTH OF STAY IN 1b <u>204 W. 10th AVE.</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>204 W. 10th AVE.</u>					2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>Anne Arundel</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pasadena MD.</u> d. STREET ADDRESS <u>34 Nicholson DR.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First <u>IRENE</u> Middle <u>L.</u> Last <u>BASTIAN</u>					4. DATE OF DEATH Month <u>8</u> - Day <u>6</u> - Year <u>1966</u>				
5. SEX <u>F</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>May 19, 1896</u>		9. AGE (In years last birthday) <u>70</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>MD.</u>		12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME <u>George Brower</u>					14. MOTHER'S MAIDEN NAME <u>Emma Heyman</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. (If give war or dates of service)		17. INFORMANT <u>Family</u>		Address <u>Home</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>0821</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) <u>Myocardial infarction & brain damage</u> DUE TO (c) <u>Arteriosclerosis</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)									INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>12/6</u> , 19 <u>65</u> , to <u>8/6</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>8/3</u> , 19 <u>66</u> , and that death occurred at <u>MD</u> , from the causes and on the date stated above.									
22a. SIGNATURE <u>Samuel Rubin</u>					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>8/8/66</u>		
22c. PHYSICIAN'S NAME (Type) <u>Samuel Rubin, M.D.</u>					22d. ADDRESS <u>203 Patapsco Avenue Baltimore, Md. 21225</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>8-9-66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Western Am</u>		23d. LOCATION (City, town or county) (State) <u>Balto 29 Md</u>			
24. FUNERAL DIRECTOR <u>McClully Funeral Home</u>					ADDRESS <u>237 Patapsco Ave</u>		25a. REC'D BY REGISTRAR <u>AUG 10 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>

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1001

[Faint, illegible handwriting throughout the page, likely bleed-through from the reverse side.]

10827

CERTIFICATE OF DEATH

10819

1. PLACE OF DEATH a. COUNTY Anne Arundel		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland		b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville		c. LENGTH OF STAY IN Jb Gmos. 26 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Crownsville State Hospital				d. STREET ADDRESS 949 Bennett Place		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) 3-#06234 Viola		First Middle Last Bivins		4. DATE OF DEATH Month Day Year 8 19 1966			
5. SEX Female		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1902	
9. AGE (In years last birthday) yrs. 64		10. USUAL OCCUPATION (Give kind of work done during 1 month before death, even if retired) Unknown		11. BIRTHPLACE (County & State, or foreign country) Unknown		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Unknown		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Hospital Records			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1538 DUE TO Gen. Chronic Peritonitis with Focal Abscess Formation (b) Carcinoma of Colon Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)		INTERVAL BETWEEN ONSET AND DEATH					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Hypertensive Cardiovascular Disease; Generalized Arteriosclerosis		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) -		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) -----					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. ----- 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) -----		20f. (City or town) (County) (State) -----	
21. I certify that (I) (this hospital) attended the deceased from 1/23, 1939, to 8/19, 1966, that (I) (we) last saw the deceased alive on 8/19, 1966, and that death occurred at 5:15 P.M. from causes and on the date stated above.							
22a. SIGNATURE Hollis Deunarine, M.D.		22b. DATE SIGNED 8/19/66		22c. PHYSICIAN'S NAME (Type) Hollis Deunarine		22d. ADDRESS Crownsville State Hospital, Maryland	
23a. BURIAL (CREMATION, REMOVAL) (Specify) 8.26.66		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY U. of Md. Med. School		23d. LOCATION (City or Town) (County) (State) Baltimore, Md.	
24. FUNERAL DIRECTOR Reese 108 W Washington		25a. REC'D BY REGISTRAR DATE AUG 29 1966		25b. REGISTRAR'S SIGNATURE Charles Judge			

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John Brown

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CERTIFICATE OF DEATH

10820

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Worcester	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville		c. LENGTH OF STAY IN lb 5mos. 14das.	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Snow Hill 23
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Crownsville State Hospital		d. STREET ADDRESS Unknown	
3. NAME OF DECEASED #31343 JAMES First Middle Last BOOEN		4. DATE OF DEATH Month 8 Day 8 Year 1966	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/15/90
9. AGE (In years last birthday) yrs. 76		10. IF UNDER 1 YEAR Months 8 Days 8 Hours 19 Min. 66	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY -----	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY USA	
13. FATHER'S NAME Deceased		14. MOTHER'S MAIDEN NAME Deceased	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT Hospital Records		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 443X IMMEDIATE CAUSE (a) CONGESTIVE HEART FAILURE DUE TO (b) HYPERTENSIVE CARDIOVASCULAR DISEASE DUE TO (c) ----- Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) -----	
20c. TIME OF INJURY Month, Day, Year Hour 10 a.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) -----	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 2/22/ , 19 66 , to 8/8/ , 19 66 , that (I) (we) last saw the deceased alive on 8/8/ , 19 66 , and that death occurred at 6:10 M, from causes on and on the date stated above.			
22a. SIGNATURE Hollis Pennington		22b. DATE SIGNED 8/8/66	
22c. PHYSICIAN'S NAME (Type) HOLLIS PENNINGTON		22d. ADDRESS Crownsville State Hospital	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY Anatomy Board of Maryland	23d. LOCATION (City or Town) (County) (State)
24. FUNERAL DIRECTOR William Reese		25a. REC'D BY REGISTRAR DATE 8/12/66	
ADDRESS 108 W. Washington St. Annapolis, Maryland		25b. REGISTRAR'S SIGNATURE Charles Judge	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
10829		Items #6 & 7 RUM #13.0 6-4-66 pc						10821			
1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> <u>MARYLAND</u>						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Caroline</u>					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie</u>				c. LENGTH OF STAY IN lb <u>7 weeks</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Federalburg</u>				d. STREET ADDRESS <u>211 Central Avenue</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>1028 Fitzallen Road</u>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <u>Ruth C. Brown</u>						4. DATE OF DEATH <u>August 10, 1966</u>					
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <u>WIDOWED</u> <input type="checkbox"/> <u>DIVORCED</u> <input type="checkbox"/>		8. DATE OF BIRTH <u>18 Nov. 1898</u>		9. AGE (In years last birthday) <u>66</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Gambrells, AA Co., Md.</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Charles W. McNemar</u>						14. MOTHER'S MAIDEN NAME <u>Etta H. Turnbaugh</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>						16. SOCIAL SECURITY NO. <u>229-36-2342</u>					
						17. INFORMANT <u>Mrs. Pauline Howard, same as 1</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <u>Ca of brain</u> <u>Carcinomatosis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO DUE TO											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)											
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)	
21. I certify that (1) <u>the deceased</u> attended the deceased from <u>June 20, 1966</u> , to <u>10 Aug. 1966</u> that (1) <u>her</u> last saw the deceased alive on <u>Aug 10, 1966</u> , and that death occurred at <u>8:15 A</u> from the causes and on the date stated above.											
22a. SIGNATURE <u>Robert Dabolins</u>						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>11 Aug., 66</u>			
22c. PHYSICIAN'S NAME (Type) <u>Robert Dabolins, M.D.</u>						22d. ADDRESS <u>400 Crain Hwy., N.W., Glen Burnie, Md.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>13 Aug. 1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Baldwin Memorial</u>		23d. LOCATION (City, town or county) <u>Millersville, Md.</u>		(State)			
24. FUNERAL DIRECTOR'S SIGNATURE <u>Kirkley Funeral Home, Glen Burnie, Md.</u>						25a. REC'D BY REGISTRAR <u>AUG 15 1966</u>		25b. REGISTRAR'S SIGNATURE <u>J Charles Judge</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit (Form 100) please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

10830

CERTIFICATE OF DEATH

10822

1. PLACE OF DEATH a. COUNTY ANNE ARUNDEL COUNTY MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LAUREL			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) KIMBROUGH ARMY HOSPITAL FT. GEO. G. MEADE				e. STREET ADDRESS 104 MORRIS DRIVE, APT #202			
3. NAME OF DECEASED (Type or print) SAUNDRA First ANN Middle CAMPBELL Last				4. DATE OF DEATH Month AUG Day 19 Year 1966			
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 19 AUG 66	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) N/A				10b. KIND OF BUSINESS OR INDUSTRY N/A		9. AGE (In years last birthday) yrs. 5 Months 1 Days 1 Hours 5 Min.	
11. BIRTHPLACE (County & State, or foreign country) ANNE ARUNDEL, MD				12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME EDSEL G. CAMPBELL				14. MOTHER'S MAIDEN NAME CHRISTLANE VINCENT			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) N/A		16. SOCIAL SECURITY NO. N/A		17. INFORMANT (father) Edsel G. Campbell, same as item #2		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) RESPIRATORY AND CARDIAC ARREST DUE TO PREMATURITY Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 20 Min.						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 1530		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) this hospital attended the deceased from 1530 19 AUG 1966 to 2130 19 Aug 66 , that (I) was last saw the deceased alive on 2120 AUG 19 1966 , and that death occurred at 2130 , from the causes and on the date stated above.							
22a. SIGNATURE Felix A. Conte, Capt, MC				22b. DATE SIGNED 8/19/66		22c. PHYSICIAN'S NAME (Type) FELIX A. CONTE, Capt, MC	
22d. ADDRESS KIMBROUGH ARMY HOSPITAL FT. GEO. G. MEADE				22e. MED. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 24 Aug. 1966		23c. NAME OF CEMETERY OR CREMATORY ARLINGTON, NATIONAL CEM.		23d. LOCATION (City, town or county) (State) ARLINGTON, VIRGINIA DE	
24. FUNERAL DIRECTOR HAROLD Spencer				ADDRESS 580 Wash St		25. REGISTRAR'S SIGNATURE Charles Judge	

SEP 7 1966



108321

CERTIFICATE OF DEATH

10823

1 PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL-Arnold	
c. LENGTH OF STAY IN 1b 1 Day		d. STREET ADDRESS Box 462, Rt. 3, Shore Acres Rd	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Anne Arundel General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First Middle Last Thelma Catherine CASTEL		4. DATE OF DEATH Month Day Year August 15 19 66	
5 SEX Female	6 COLOR OR RACE White	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1914 9 AGE (In years last birthday) 51 yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Secretary Finance Co		10b. KIND OF BUSINESS OR INDUSTRY Baltimore, Md	11 BIRTHPLACE (County & State, or foreign country) USA
13. FATHER'S NAME Unknown		14. MOTHER'S M maiden NAME Unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO Unknown	
17. INFORMANT Leo J. Castel		Address Albino	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Massive B. Pneumonia, Bilateral DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 5 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 8/15 , 19 66 , to 8/15 , 19 66 that (I) (we) lost saw the deceased alive on 8/15 19 66 and that death occurred at 10:20 P.M. from causes and on the date stated above.			
22a. SIGNATURE Margie Klawns		M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED 8/16/66
22c. PHYSICIAN'S NAME (Type) Margie Klawns		22d. ADDRESS 315 Southgate Ave., Annapolis, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 8-19-66	23c. NAME OF CEMETERY OR CREMATORY Northland Heights	23d. LOCATION (City or Town) (County) (State) Md
24. FUNERAL DIRECTOR Baroness Funeral Home		25. FILED BY REGISTRAR 11 1966	25b. REGISTRAR'S SIGNATURE James Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

10832

CERTIFICATE OF DEATH

10824

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Anne Arundel General Hospital		d. STREET ADDRESS 19 Bloomsbury Square	
3. NAME OF DECEASED (Type or print) First Rita Middle M. Last CATTERTON		4. DATE OF DEATH Month August Day 19 Year 1966	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 13, 1919
9. AGE (In years last birthday) yrs 47		10. IF UNDER 1 YEAR Months 1 Days 19 Hours 19 Min 19	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Civil Service		10b. KIND OF BUSINESS OR INDUSTRY U.S. Govt. Ret.	
11. BIRTHPLACE (Country & State or foreign country) Allegany, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME ROY DAVIS		14. MOTHER'S MAIDEN NAME GRACE MAUSE	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO	
17. INFORMANT HERBERT CATTERTON #2		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Probable Cardiac Arrhythmia DUE TO (b) A.S.C.V.D. and likely recent myoc. infarction DUE TO (c) Chronic Cong. Heart Failure		INTERVAL BETWEEN ONSET AND DEATH Immediate 1 day? 3 weeks.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Long term diabetes mellitus; Arterio. sclerosis obliterans; Lithology		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (the undersigned) attended the deceased from 1960 to 8/19 , 19 66 that (I) (the undersigned) saw the deceased alive on 8-17 , 19 66 , and that death occurred at 6:35 PM , from causes and on the date stated above.			
22a. SIGNATURE Peter F. Verkouw		22b. DATE SIGNED 8/22/66	
22c. PHYSICIAN'S NAME (Type) Peter F. Verkouw, M.D.		22d. ADDRESS 1407 Forest Drive, Annapolis, Md.	
23a. BURIAL-CREATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 8-23-66	
23c. NAME OF CEMETERY OR CREMATORY CEDAR Bluff		23d. LOCATION (City or Town) (County) (State) ANNAPOLIS MD.	
24. FUNERAL DIRECTOR John M. Taylor & Sons Annapolis, Md.		25a. REC'D BY REGISTRAR DATE AUG 23 1966	
25b. REGISTRAR'S SIGNATURE Charles J. J...			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

CERTIFICATE OF DEATH

10832

10825

1. PLACE OF DEATH a. COUNTY <u>ANNE ARUNDEL</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>A.A. Co.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ST. MARGARETS</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ARNOLD</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>BAY MANOR NURSING HOME</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>HARRY C. CHANEY</u>		4. DATE OF DEATH Month Day Year <u>8 21 1966</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-31-1882</u>
9. AGE (In years last birthday) <u>83</u> yrs.		10. IF UNDER 1 YEAR Months Days <u>8 21</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CARPENTER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Building</u>	
11. BIRTHPLACE (County & State or foreign country) <u>A.A. Co. MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>ROBERT CHANEY</u>		14. MOTHER'S MAIDEN NAME <u>Kattie Long</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>ELIZABETH CHANEY #2</u>	
17. INFORMANT <u>ELIZABETH CHANEY</u>		Address <u>#2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac arrest,</u> DUE TO (b) <u>Arteriosclerotic cardiovascular disease</u> DUE TO (c) _____			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Senile pulmonary emphysema</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>July</u> , 19 <u>65</u> , to <u>August</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>7/21/66</u> , and that death occurred at <u>8:30 A.M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>John Hederman</u>		22b. DATE SIGNED <u>8/21/66</u>	
22c. PHYSICIAN'S NAME (Type) <u>JOHN HEDERMAN</u>		22d. ADDRESS <u>FOREST DR. ANNAPOLIS, MD.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>8-24-66</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>ASBURY</u>		23d. LOCATION (City, town or county) (State) <u>ARNOLD MD.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Taylor & Sons</u>		25a. REC'D BY REGISTRAR DATE <u>AUG 23 1966</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

TO HOSPITAL: [REDACTED] **ATTENDING PHYSICIAN:** The law requires that the death certificate be executed [REDACTED] 24 hours after death. Page 4 [REDACTED] be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, [REDACTED] by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15
15M 7-62

Page 1

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1. The first part of the report

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND										
10834					10826					
1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis			c. LENGTH OF STAY IN 1b 42 yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 413 Chesapeake Ave.					d. STREET ADDRESS 413 Chesapeake Avenue			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) EVA MAM CHASE			First Middle Last		4. DATE OF DEATH Aug. 29 19 66		Month Day Year			
5. SEX Female		6. COLOR OR RACE Negro		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Aug 12-1896		9. AGE (In years last birthday) 70 yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Waitress			10b. KIND OF BUSINESS OR INDUSTRY *****		11. BIRTHPLACE (County & State, or foreign country) Phil. Pa.			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME James Barnes					14. MOTHER'S MAIDEN NAME Hanna ?					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No			16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Robert Chase-413 Chesapeake Ave. Anna Md.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> DUE TO (b) <u>Choking</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) <u>Heart Disease</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								INTERVAL BETWEEN ONSET AND DEATH 6 days		
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 7-27-51, 1951, to 8-29-66, 1966, that (I) (we) last saw the deceased alive on 8-28-66, 1966, and that death occurred at 2 P.M. from the causes and on the date stated above.										
22a. SIGNATURE <u>A. T. Allen</u>					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 8-29-66	
22c. PHYSICIAN'S NAME (Type) A + ALLEN					22d. ADDRESS 62 Cathedral Ex					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF Sept. 3-66		23c. NAME OF CEMETERY OR CREMATORY Pine Lawn		23d. LOCATION (City, town or county) (State) Bestgate Rd. Anna. Md.			
24. FUNERAL DIRECTOR C.E. Hicks III Annapolis, Md.					ADDRESS		25a. REC'D BY REGISTRAR SEP 7 1966			
					25b. REGISTRAR'S SIGNATURE f Charles Judge					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
10835					10827				
1. PLACE OF DEATH a. COUNTY AA					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY AA				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie			c. LENGTH OF STAY IN 1b MARYLAND		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pasadena Md				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) North Orundel Hospital					d. STREET ADDRESS Rt 6 Mt Pleasant Beach				
3. NAME OF DECEASED (Type or print) CLARA I COLDER					4. DATE OF DEATH Month 8 Day 22 Year 1966				
5. SEX F		6. COLOR OR RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 11/24/87		9. AGE (In years last birthday) 78 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) VIRGINIA			12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME William S Skidmore					14. MOTHER'S MAIDEN NAME Eliza V				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no					16. SOCIAL SECURITY NO. 215056567		17. INFORMANT Ruth H. Clauser Pasadena, Md.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) +4 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO Encephalomalacia, rt. Hemip DUE TO HCLVD PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)									
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)									
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from 8/15, 1966 to 8/22, 1966, that (I) (we) last saw the deceased alive on 8/22/66 19, and that death occurred at 6:27 PM, from the causes and on the date stated above.									
22a. SIGNATURE J. B. Ramirez									
22b. DATE SIGNED 8/22/66									
22c. PHYSICIAN'S NAME (Type) J. B. RAMIREZ M.D.									
22d. ADDRESS 3427 ANNAPOLIS RD Baltimore 27 Md 1671 NORTHBOURNE RD Baltimore 12 Md									
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 8/26/66		23c. NAME OF CEMETERY OR CREMATORY BALTIMORE NATIONAL CEM.			23d. LOCATION (City, town or county) (State) BALTIMORE, MD.		
24. FUNERAL DIRECTOR HOWARD H. HUBBARD 4107 WILKENS AVE. 21229					25a. REC'D BY REGISTRAR AUG 24 1966				
					25b. REGISTRAR'S SIGNATURE Charles Judge				



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. The permit to remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY ANNE ARUNDEL b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT GEORGE G MEADE c. LENGTH OF STAY IN b 2 Hours d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) KIMBROUGH ARMY HOSPITAL				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MARYLAND b. COUNTY ANNE ARUNDEL c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BOWIE, MARYLAND d. STREET ADDRESS 12504 KILLIAN LANE e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) OTTO				4. DATE OF DEATH COLLINS III AUGUST 30 1966				5. SEX MALE 6. COLOR OR RACE CAU 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH 30 AUGUST 1966 9. AGE (in years last birthday) 2 10. IF UNDER 1 YEAR 11. IF UNDER 24 HRS. 12. CITIZEN OF WHAT COUNTRY? U.S.A.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NEWBORN 10b. KIND OF BUSINESS OR INDUSTRY NEWBORN 11. BIRTHPLACE (County & State, or foreign country) ANNE ARUNDEL, MARYLAND 12. CITIZEN OF WHAT COUNTRY? U.S.A.				13. FATHER'S NAME OTTO COLLINS Jr. 14. MOTHER'S MAIDEN NAME MARIA KRETCHMEIER				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO 16. SOCIAL SECURITY NO. NONE 17. INFORMANT FATHER			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>PREMATURITY</u> CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 21. I certify that (I) (this hospital) attended the deceased from 30 Aug 1966 to 30 Aug 1966 that (I) (we) last saw the deceased alive on 30 Aug 1966, and that death occurred at 7 A.M. from the causes and on the date stated above. 22a. SIGNATURE 22b. DATE 22c. PHYSICIAN'S NAME (Type) THEODORE F. TOULAN 22d. ADDRESS KIMBROUGH ARMY HOSPITAL 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial 23b. DATE THEREOF Sept. 2, 1966 23c. NAME OF CEMETERY OR CREMATORY Arlington National Cem. 23d. LOCATION (City, town or county) Arlington, Virginia 24. FUNERAL DIRECTOR'S SIGNATURE Harold S. Webb 25a. REC'D BY REGISTRAR DATE SEP 8 1966 25b. REGISTRAR'S SIGNATURE J. Charles Judge											

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10837

CERTIFICATE OF DEATH

10828

1 PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c LENGTH OF STAY IN 1b Life	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Anne Arundel General Hospital		e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) Catherine Madeline COOPER		4 DATE OF DEATH Month August Day 4 Year 1966	
5 SEX Female	6 COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH Oct. 22, 1898
9 AGE (In years last birthday) yrs. 67		10. IF UNDER 1 YEAR Months Days Hours Min 67	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		10b. KIND OF BUSINESS OR INDUSTRY *****	
11 BIRTHPLACE (County & State, or foreign country) Anne Arundel Maryland		12 CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME John Cooper		14. MOTHER'S MAIDEN NAME Henrietta Frye	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No *****		16. SOCIAL SECURITY NO. 215-24-9801	
17 INFORMANT Miss Vonitta E. Sumner		Address Annapolis, Md	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Massive cerebral hemorrhage DUE TO H.A.S.C.V.D. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____		INTERVAL BETWEEN ONSET AND DEATH 4 days years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Extreme Obesity; diabetes mellitus		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (we) attended the deceased from _____, 19____, to Aug. 4, 1966 , that (I) (we) saw the deceased alive on Aug. 4, 1966 , and that death occurred at _____ M, from causes and on the date stated above.			
22a. SIGNATURE Peter F. Verkouw		22b. DATE SIGNED 8/4/66	
22c. PHYSICIAN'S NAME (Type) Peter F. Verkouw, M.D.		22d. ADDRESS 1407 Forest Drive, Annapolis, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 8/8/1966	23c. NAME OF CEMETERY OR CREMATORY Asbury church	23d. LOCATION (City or Town) (County) (State) Annapolis A.A.Co Md
24. FUNERAL DIRECTOR C.E. Hicks, III		25a. REC'D BY REGISTRAR DATE AUG 8 1966	
25b. REGISTRAR'S SIGNATURE Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

10838

10829

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore City</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Crownsville</u>		c. LENGTH OF STAY IN 1b <u>2 days</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Crownsville State Hospital</u>				d. STREET ADDRESS <u>901 St. Paul Street</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) #33061 First <u>A. Bernadine</u> Middle <u>Beth</u> Last <u>Crosby</u>				4. DATE OF DEATH Month <u>8</u> Day <u>23</u> Year <u>19 66</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8/26/04</u>	9. AGE (In years last birthday) <u>62</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Unknown Seamstress</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Tiralla Co.</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Unknown Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Unknown William E. Carter</u>				14. MOTHER'S MAIDEN NAME <u>Unknown Sophia M. Schweikert</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT <u>Hospital Records</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction?</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary Arteriosclerosis</u> DUE TO (c) <u> </u>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) <u> </u>					
20c. TIME OF INJURY Month, Day, Year <u>Hour 2:00 p.m. 19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>		20f. (City or town) (County) (State) <u> </u>	
21. I certify that (I) (this hospital) attended the deceased from <u>8/21/1966</u> to <u>8/23/1966</u> , that (I) (we) last saw the deceased alive on <u>8/23/1966</u> , and that death occurred at <u>8:15 P.</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>[Signature]</u>				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>8/24/66</u>	
22c. PHYSICIAN'S NAME (Type) <u>L. Benedict, M. D.</u>				22d. ADDRESS <u>Crownsville State Hospital, Maryland</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>8/27/66.</u>		23c. NAME OF CEMETERY OR CREMATORY <u>New Cathedral Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Baltimore, Md.</u>	
24. FUNERAL DIRECTOR <u>Leonard J. Ruck Inc. Balto. Md. 21214</u>				25a. REC'D BY REGISTRAR <u>AUG 25 1966</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word 'pending' in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health at its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

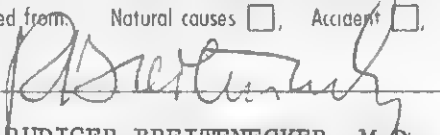

VR A15ME (5)
6M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10830

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10830

1 PLACE OF DEATH a COUNTY ANNE ARUNDEL MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a STATE Maryland b COUNTY Anne Arundel	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Arnold		c LENGTH OF STAY IN 1b Life	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Rte. #3 - Box 8		d STREET ADDRESS Rte. #3 - Box 8	
3 NAME OF DECEASED (Type or print) JAMES Norman DANIELS		4 DATE OF DEATH Month 8- Day 15 Year 19 66	
5 SEX Male	6 COLOR OR RACE Colored	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 3-3-1953
9 AGE (In years last birthday) 13 yrs		10 IF UNDER 1 YEAR Months 13 Days 13 Hours 13 Min 13	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student		10b KIND OF BUSINESS OR INDUSTRY Student	
11 BIRTHPLACE (State or foreign country) Pennsylvania		12 CITIZEN OF WHAT COUNTRY? U.S.A.	
13 FATHER'S NAME Julian Daniels		14 MOTHER'S MAIDEN NAME Lillie Mae Berry	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes no, or unknown) (If yes give war or dates of service) No		16 SOCIAL SECURITY NO. None	
17. INFORMANT Lillie Mae Daniels		Address Rt 3 Box 8	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH CAUSED BY: IMMEDIATE CAUSE (a) Gunshot wound of head 776 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 776 X DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) Apparently shot self in head	
20c TIME OF INJURY Month, Day, Year Hour a.m. 11:30 PM 8-15 1966	20d INJURY OCCURRED Where <input type="checkbox"/> at work <input checked="" type="checkbox"/> at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home	20f (City or town) (County) (State) Arnold Anne Arundel Md.
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE  EXAMINER'S NAME (Type) RUDIGER BREITENECKER, M.D.		22. DATE SIGNED 8-15-66	
23a BURIAL, CREMATION REMOVAL (Specify) Burial		23b DATE THEREOF 8-20-66	
23c NAME OF CEMETERY OR CREMATORY Mt Calvary Methodist		23d LOCATION (City or Town) (County) (State) Arnold A.A. Co, Md	
24 FUNERAL DIRECTOR C.E. Hicks, 111		ADDRESS Annapolis, Md	
25a REC'D BY REGISTRAR AUG 23 1966		25b REGISTRAR'S SIGNATURE 	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

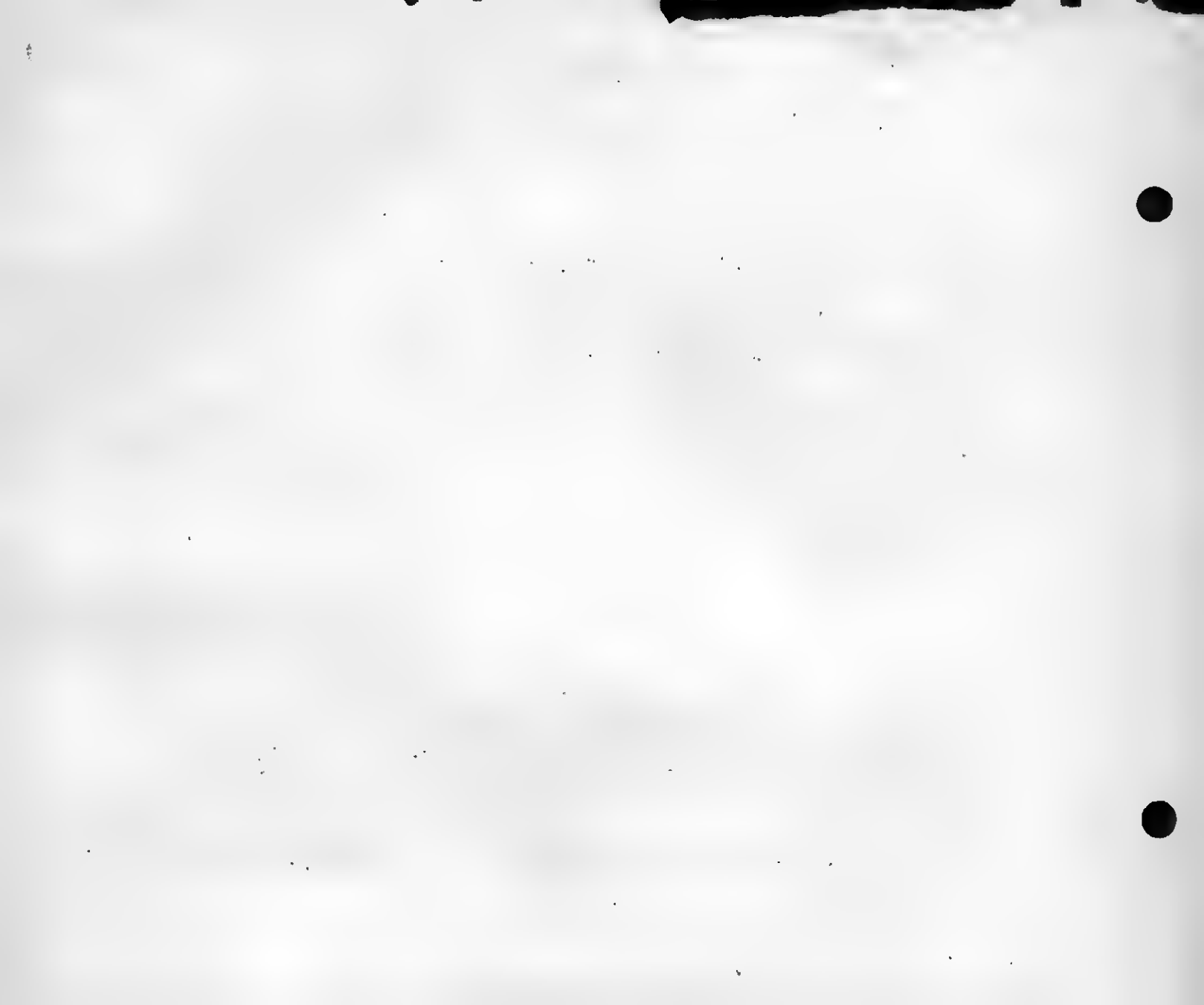
VR A15 (4)
20M 1/65

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

10840

10831

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY H H			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Glen Burnie		c. LENGTH OF STAY IN 1b 4 years		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Glen Burnie			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) North Arundel Hospital				d. STREET ADDRESS Rt 1 Box 293 D		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First JOHN Middle MAHLON Last DAVID				4. DATE OF DEATH Month 8 Day 20 Year 1966			
5. SEX M	6. COLOR OR RACE N	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/14/1917	9. AGE (In years last birthday) 68 yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED - PORTER		10b. KIND OF BUSINESS OR INDUSTRY 528th Ave N.Y. city		11. BIRTHPLACE (County & State, or foreign country) South Carolina		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. 058050109		17. INFORMANT Mrs. Davis (wife)		Address Same	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO (b) Bronchogenic Carcinoma DUE TO (c) of the lung.						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 8/12/66 , 19 to 8/20/66 , 19, that (I) (we) last saw the deceased alive on 8/19/66 , 19, and that death occurred at 8:30 AM , from the causes and on the date stated above.							
22a. SIGNATURE J. B. Ramirez						22b. DATE SIGNED 8/20/66	
22c. PHYSICIAN'S NAME (Type) JORGE B. RAMIREZ M D		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22d. ADDRESS 3927 ANNAPOLIS RD Baltimore 23 Md. 1672 NORTHBOURNE RD Baltimore 12 Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 8/24/66		23c. NAME OF CEMETERY OR CREMATORY Hall Meth. Ch. Cem.		23d. LOCATION (city, town or county) (State) A.A. Co. Md.	
24. FUNERAL DIRECTOR Sullivan Funeral Home - N. Arlington Ave.		ADDRESS 1011-13 Balto		25a. REC'D BY REGISTRAR AUG 23 1966		25b. REGISTRAR'S SIGNATURE J. Charles Judge	



TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 of 3. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

(M)

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

10841

10832

1. PLACE OF DEATH a. COUNTY <u>ANNE ARUNDEL</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) e. STATE <u>MD</u> b. COUNTY <u>ANNE ARUNDEL</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>GLEN BURNIE</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>GLEN BURNIE - 21061</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>NORTH ARUNDEL GEN'L HOSP</u>		d. STREET ADDRESS <u>1206 - HUTTON DRIVE</u>	
3. NAME OF DECEASED (Type or print) <u>JAMES TROY DAVIS</u>		4. DATE OF DEATH <u>MON, AUG - 1 1966</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 8, 1902</u>
9. AGE (In years last birthday) <u>63</u> yr.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED PAINTER</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>JAMES SHRIVER DAVIS</u>		14. MOTHER'S MAIDEN NAME <u>SARAH FRANCES YORKE</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or date of service) <u>Yes - 9/26/19 - 3/29/20</u>		16. SOCIAL SECURITY NO. <u>POTRICIA A. COOK (SARAH) DAUGHTER</u>	
17. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardio - Vascular Disease</u> <u>241X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>Bronchial Asthma</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>1-2 hr</u> <u>2-4 hr</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)			
18a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		18b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
19a. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		19b. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20a. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20b. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Feb 1963</u> to <u>8/1/66</u> , that (I) (we) last saw the deceased alive on <u>8/1/66</u> 1966, and that death occurred at <u>7:45 P</u> M. from the causes and on the date stated above.			
22a. SIGNATURE <u>Charles L. Ball Jr</u>		22b. DATE SIGNED <u>8/3/66</u>	
22c. PHYSICIAN'S NAME (Type) <u>CHARLES L. BALL, JR</u>		22d. ADDRESS <u>Linthicum Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>Aug-5-1966</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>BALTO. U.S. NAT'L CEM</u>		23d. LOCATION (City, town or county) (State) <u>BALTO, Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>CURTIS E. EVANS</u>		25. REC'D BY REGISTRAR <u>James J. Jager</u>	
ADDRESS <u>1400 S. CHARLES</u>		DATE <u>4 1966</u>	

C. H. E. FAYNE

TO HOSPITAL OR ATTENDING PHYSICIAN: The death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item 7 Film 100 8/31/66 mh

10842

CERTIFICATE OF DEATH

10833

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Anne Arundel General Hospital		d. STREET ADDRESS 1302 McKinley St.,	
3. NAME OF DECEASED (Type or print) First Middle Last George Harold DEARBORN, Sr.		4. DATE OF DEATH Month Day Year August 24 19 66	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 29, 1896
9. AGE (n years lost birthday) yrs. 70		10. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Engineer		10b. KIND OF BUSINESS OR INDUSTRY U.S. Gov't.	
11. BIRTHPLACE (County & State, or foreign country) Kentucky		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME George Dearborn		14. MOTHER'S MAIDEN NAME "Unk."	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes or unknown) (If yes give war or dates of service) Yes WW I		16. SOCIAL SECURITY NO	
17. INFORMANT Geo. H. Dearborn, Jr.		Address # 2	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac arrest DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Acute coronary occlusion DUE TO (c) Atherosclerosis		INTERVAL BETWEEN ONSET AND DEATH 20 hrs. 20 hrs. 10 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic passive congestion; renal insufficiency; multiple aneurysms; pneumonia			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (the hospital) attended the deceased from August 5, 1966 , to Aug. 24, 1966 , that (I) (we) last saw the deceased alive on Aug. 24 19 66 , and that death occurred at 4:20 PM M, from causes and on the date stated above.			
22a. SIGNATURE Merton T. Waite		22b. DATE SIGNED 8-25-66	
22c. PHYSICIAN'S NAME (Type) MERTON T. Waite, M.D.		22d. ADDRESS 21 Cathedral St., Annapolis, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 8-29-1966	
23c. NAME OF CEMETERY OR CREMATORY Arlington Nat'l.		23d. LOCATION (City or Town) (County) (State) Arlington Va.	
24. FUNERAL DIRECTOR John M. Taylor & Sons		25a. REC'D BY REGISTRAR John M. Taylor	
25b. REGISTRAR'S SIGNATURE John M. Taylor		DATE AUG 29 1966	



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10842

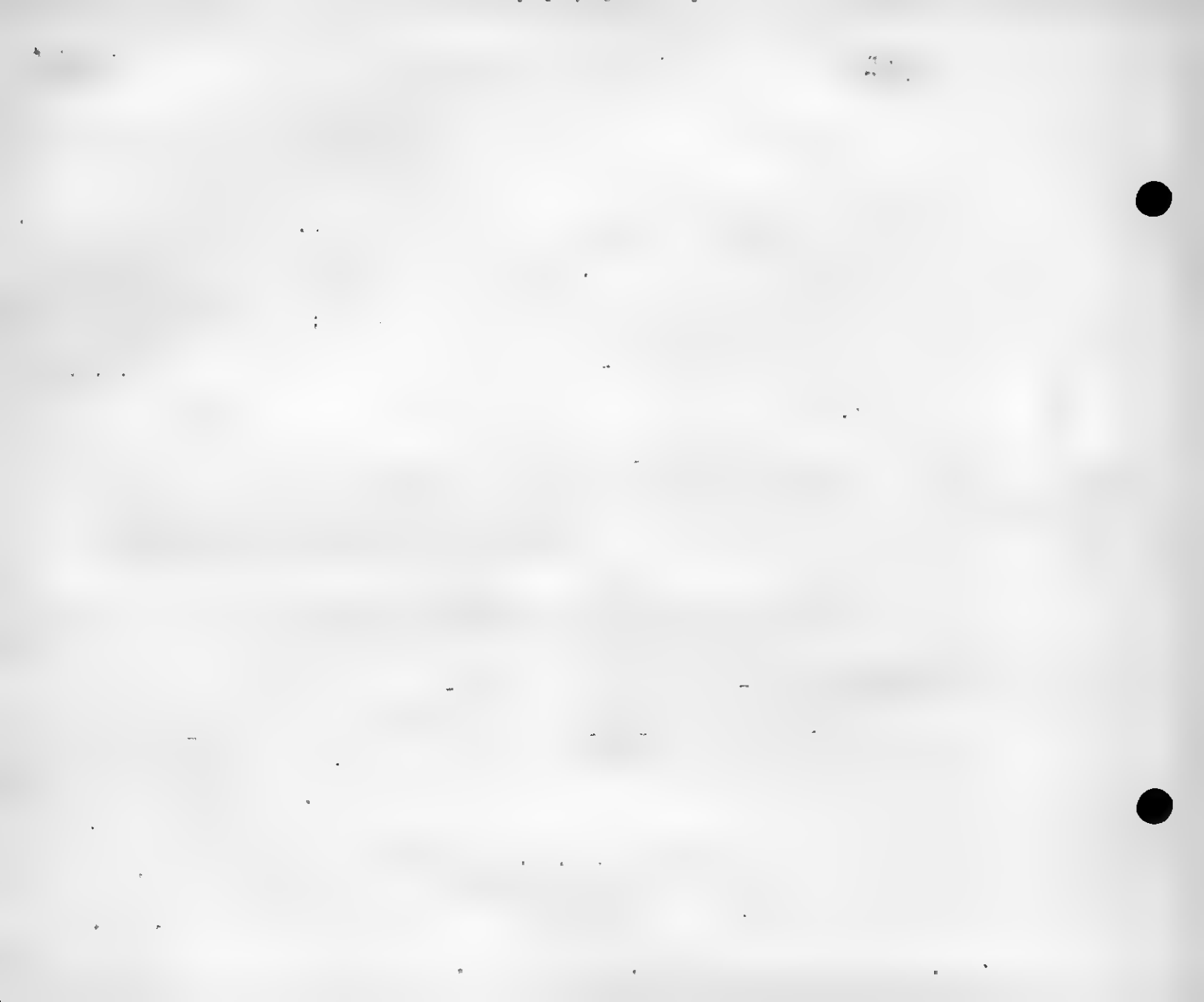
CERTIFICATE OF DEATH

10834

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore City	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville		c. LENGTH OF STAY IN 1b 11 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Crownsville State Hospital		d. STREET ADDRESS 700 Park Ave.	
3. NAME OF DECEASED (Type or print) 3-#33027 Mary C. Deck		4. DATE OF DEATH Month 8 Day 30 Year 1966	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH October 16, 1891
9. AGE (In years lost birthday) 74 yrs.		10. IF UNDER 1 YEAR Months 0 Days 30 Hours 00 Min. 00	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Secretary		10b. KIND OF BUSINESS OR INDUSTRY -----	
11. BIRTHPLACE (County & State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John H. Deck		14. MOTHER'S MAIDEN NAME Katherine FRANKIE	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO. 216-09-0655	
17. INFORMANT Hospital Records		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Hypostatic Pneumonia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) Generalized & Cerebral Arteriosclerosis DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Uremia		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) ---		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) -----	
20c. TIME OF INJURY Month, Day, Year Hour a.m. --- p.m. --- 19 66		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) -----		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 8/19 , 19 66 , to 8/30 , 19 66 , that (I) (we) last saw the deceased alive on 8/30 , 19 66 , and that death occurred at 12:15 M. , from causes and on the date stated above.			
22a. SIGNATURE <i>Lionel McHenry Mapp</i>		22b. DATE SIGNED 8/30/66	
22c. PHYSICIAN'S NAME (Type) Lionel McHenry Mapp, M. D.		22d. ADDRESS Crownsville State Hospital, Maryland	
23a. BURIAL CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 9/2/66	
23c. NAME OF CEMETERY OR CREMATORY CATHEDRAL		23d. LOCATION (City or Town) (County) (State) BALTIMORE, MD.	
24. FUNERAL DIRECTOR H.W. MEARS & SON 805 N. CALVERT ST.		25a. REC'D BY REGISTRAR SEP 1 1966	
25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10844

CERTIFICATE OF DEATH

10835

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. LENGTH OF STAY IN 1b 2 days	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) West River
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Anne Arundel General Hospital		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First Alice Middle Jeanette Last DIXON		4. DATE OF DEATH Month August Day 16 Year 1966	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 11, 1900
9. AGE (In years and birthday) 66 yrs		10. IF UNDER 1 YEAR Months 1 Days 19 Hours 19 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME JOSEPH H. WARD		14. MOTHER'S MAIDEN NAME SARAH E. HALL	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO. 216365119	
17. INFORMANT ARTHUR DIXON		Address West River, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Respiratory failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized metastatic disease DUE TO (c) Hodgkin's Sarcoma			INTERVAL BETWEEN ONSET AND DEATH 36 hrs 2 months 5 months
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (MD Hospital) attended the deceased from July , 19 62 , to Aug. 16 , 19 66 , that (I) (was) saw the deceased alive on Aug. 16 , 19 66 , and that death occurred at 9:25 PM , from causes on and on the date stated above.			
22a. SIGNATURE Sylvia M. Lim		22b. DATE SIGNED 8/17/66	
22c. PHYSICIAN'S NAME (Type) Sylvia Lim, M.D.		22d. ADDRESS Mayo Road, Edgewater, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 8-20-66	23c. NAME OF CEMETERY OR CREMATORY QUAKER	23d. LOCATION (City or town) (County) (State) Salesville, Md.
24. FUNERAL DIRECTOR Thomas Kennedy Salisbury, Md.		25a. REC'D BY REGISTRAR DATE AUG 25 1966	
		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



CERTIFICATE OF DEATH

10836

10845

1. PLACE OF DEATH a. COUNTY Anne Arundel .. MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Md. b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie		c. LENGTH OF STAY IN 1b 24 Days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) North Arundel Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Route 7 North Shore Pasadena P.C. 21122	
		f. STREET ADDRESS 189 D.	
3. NAME OF DECEASED (Type or print) First Elmer Middle F. Last Dothe		4. DATE OF DEATH Month August Day 26 Year 1966	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 15, 1901
9. AGE (In years last birthday) 65 yrs.		10. IF UNDER 1 YEAR Months 26 Days 19 Hours 66	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Div. Service Manager The Mack Co.		10b. KIND OF BUSINESS OR INDUSTRY Ohio	
11. BIRTHPLACE (County & State, or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Frank Dothe		14. MOTHER'S MAIDEN NAME Pauline Fister	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. 215-09-6473	
17. INFORMANT Edith M. Dothe		Address Pasadena P.O. North Shore, 21122	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Staphylococcal Septicemia 0531 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) DUE TO (c) DUE TO			INTERVAL BETWEEN ONSET AND DEATH 4 weeks
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Laleneer Cirrhosis			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 8/2 , 1966, to 8/26 , 1966, that (I) (we) last saw the deceased alive on 8/25 , 1966, and that death occurred at 2 P M, from causes and on the date stated above.			
22a. SIGNATURE Edith M. Dothe		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED 8/26/66
22c. PHYSICIAN'S NAME (Type) H.T.O. HERLIHY		22d. ADDRESS 5 Central Ave. Glen Burnie	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 8-29-1966	23c. NAME OF CEMETERY OR CREMATORY Woodlawn	23d. LOCATION (City or Town) (County) (State) Woodlawn Md.
24. FUNERAL DIRECTOR G. Howard Strong 3207 W. North Ave.,		25a. REC'D BY REGISTRAR AUG 29 1966	25b. REGISTRAR'S SIGNATURE Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MEDICAL CERTIFICATION

<div style="display: flex; justify-content: space-between;"> <div> <p>MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</p> </div> <div style="text-align: center;"> <p>CERTIFICATE OF DEATH</p> </div> <div style="text-align: right;"> <p>10837</p> </div> </div>											
<p>1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND</p>						<p>2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel</p>					
<p>b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Annapolis</p>				<p>c. LENGTH OF STAY IN 1b 1 hr, 50 min.</p>		<p>c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Annapolis</p>				<p>d. STREET ADDRESS Winchester Road</p>	
<p>d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) U.S. Naval Hospital</p>						<p>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></p>					
<p>3. NAME OF DECEASED (Type or print) First Leonard Middle (n) Last Doughty</p>			<p>4. DATE OF DEATH Month August Day 8 Year 1966</p>			<p>5. SEX M</p>			<p>6. COLOR OR RACE Caucasian</p>		
<p>7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/></p>			<p>8. DATE OF BIRTH 4-26-1894</p>			<p>9. AGE (In years last birthday) 72 yrs.</p>			<p>IF UNDER 1 YEAR: Months 72 Days 0 Hours 0 Min. 0</p>		
<p>10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired USN</p>				<p>10b. KIND OF BUSINESS OR INDUSTRY -</p>		<p>11. BIRTHPLACE (County & State, or foreign country) Texas</p>			<p>12. CITIZEN OF WHAT COUNTRY? USA</p>		
<p>13. FATHER'S NAME Unknown</p>						<p>14. MOTHER'S MAIDEN NAME Unknown</p>					
<p>15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes</p>				<p>16. SOCIAL SECURITY NO. 1917-1946 (29yrs) 220-36-8226</p>		<p>17. INFORMANT Address Mrs. Doughty, Winchester Road, Annapolis, Md</p>					
<p>18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction 4201 DUE TO (b) Atherosclerotic Heart Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)</p>											
<p>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Carcinoma of Prostate Metastatic</p>										<p>19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/></p>	
<p>20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</p>				<p>20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)</p>							
<p>20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.</p>				<p>20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/></p>		<p>20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)</p>		<p>20f. (City or town) (County) (State)</p>			
<p>21. I certify that (I) (this hospital) attended the deceased from 7 August, 1966, to 8 August, 1966, that (I) (we) last saw the deceased alive on 8 August 19 66 and that death occurred at 1:49 AM, from the causes and on the date stated above.</p>											
<p>22a. SIGNATURE <i>Harold E. Shute</i></p>						<p>22b. DATE SIGNED</p>					
<p>22c. PHYSICIAN'S NAME (Type) H. E. SHUTE LCDR MC USN</p>						<p>22d. ADDRESS U.S. Naval Hospital</p>					
<p>23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation</p>				<p>23b. DATE THEREOF 9 Aug 1966</p>		<p>23c. NAME OF CEMETERY OR CREMATORY Greenmount Crematory</p>		<p>23d. LOCATION (City, town or county) (State) Baltimore, Maryland</p>			
<p>24. FUNERAL DIRECTOR Burgee Funeral Home, 3631 Falls Rd., Balto. Md.</p>						<p>25a. REC'D BY REGISTRAR DATE AUG 12 1966</p>					
<p>By: <i>Harold E. Shute</i></p>						<p>25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i></p>					

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10847

CERTIFICATE OF DEATH

10838

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY <i>Anne Arundel</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Md.</i> b. COUNTY <i>Anne Arundel</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Riviera Beach</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Riviera Beach</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>238 Kenwood Road</i>		d. STREET ADDRESS <i>238 Kenwood Road</i>	
3 NAME OF DECEASED (Type or print) First <i>Harry</i> Middle <i>B.</i> Last <i>Durkee</i>		4. DATE OF DEATH Month <i>August</i> Day <i>2</i> Year <i>1966</i>	
5 SEX <i>male</i>	6 COLOR OR RACE <i>white</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>9-16-1892</i>
9. AGE (In years last birthday) <i>73</i> yrs		10. IF UNDER 1 YEAR Months <i>0</i> Days <i>0</i> Hours <i>0</i> Min <i>0</i>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Ret. Salesman</i>		12. KIND OF BUSINESS OR INDUSTRY <i>Durkee Enterpr.</i>	
13. BIRTHPLACE (County & State, or foreign country) <i>Maryland</i>		14. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
15. FATHER'S NAME <i>Harry B. Durkee</i>		16. MOTHER'S MAIDEN NAME <i>Alberta Deveraunex</i>	
17. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <i>yes WWI</i>		18. SOCIAL SECURITY NO <i>214018138</i>	
19. INFORMANT <i>William J. Lynsh</i>		Address <i>same</i>	
19. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral Vascular Accident</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Anteroselective Cordis Vascular Disease</i> DUE TO (c) <i></i>		INTERVAL BETWEEN ONSET AND DEATH <i>12 hours</i> <i>5 yrs</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Diabetes Mellitus</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACC. DENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <i>19</i> p.m. <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21 I certify that (I) (this hospital) attended the deceased from <i>JUNE 19, 1966</i> to <i>AUG 2, 1966</i> that (I) (we) last saw the deceased alive on <i>AUG. 2, 1966</i> , and that death occurred at <i>6:20 AM</i> , from causes and on the date stated above			
22a. SIGNATURE <i>J. Brady Smith</i>		22b. DATE SIGNED <i>8/3/66</i>	
22c. PHYSICIAN'S NAME (Type) <i>J. BRADY SMITH</i>		22d. ADDRESS <i>RIVIERA BEACH, MD</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>entombment</i>	23b. DATE THEREOF <i>8-5-66</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Lorraine Mausoleum</i>	23d. LOCATION (City or Town) (County) (State) <i>Baltimore, Md.</i>
24. FUNERAL DIRECTOR <i>Leonard J. Kuck Inc Baltimore, Md.</i>		25a. REC'D BY REGISTRAR DATE <i>AUG 8 1966</i>	
		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

VA 151 (4)
20 M 1/66

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed with in 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

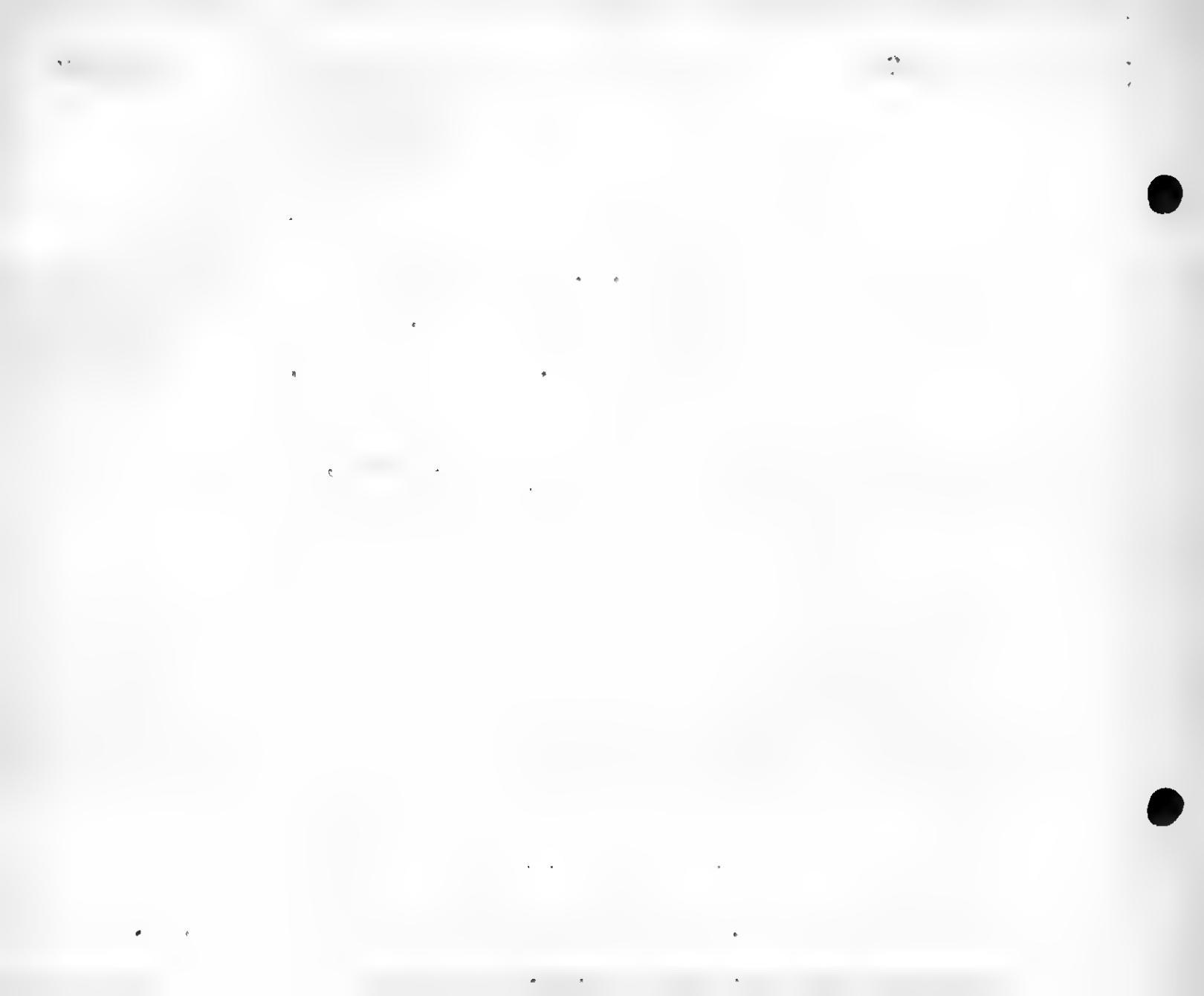
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health at its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

10848

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10839

1 PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2 USUAL RESIDENCE (Where deceased lived if institution. Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) North Arundel Glen Burnie		c LENGTH OF STAY IN 1b Glen Burnie	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) North Arundel Hospital		d STREET ADDRESS 1206 Kimberly Lane e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Hilda T. R. Fifield		4 DATE OF DEATH Month Day Year August 7 1966	
5 SEX Female	6 COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 11 Apr. 1919
9 AGE (in years) (last birthday) 47 yrs		10 UNDER 1 YEAR Months Days 47	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Research		10b KIND OF BUSINESS OR INDUSTRY Catylist Corp.	
11 BIRTHPLACE (State or foreign country) Baltimore, Md.		12 CITIZEN OF WHAT COUNTRY? USA	
13 FATHER'S NAME August Klein		14. MOTHER'S MAIDEN NAME Barbara Welsh	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. Paul E. Fifield, same as 2	
17. INFORMANT Paul E. Fifield, same as 2		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Focal fibrosis of myocardium, etiology DUE TO undetermined Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) (c) PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of item 18.)	
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Charles S. Springate EXAMINER'S NAME (Type) Charles S. Springate, M.D.		22. DATE SIGNED August 8, 1966 CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> Address (Street, city, town, or county)	
23a BURIAL, CREMATION, REMOVAL (Specify) Burial	23b DATE THEREOF 11 Aug. 1966	23c NAME OF CEMETERY OR CREMATORY Baltimore National	23d LOCATION (City or Town) (County) (State) Baltimore, Md.
24 FUNERAL DIRECTOR Kirkley Funeral Home, Glen Burnie, Md.		25a REC'D BY REGISTRAR AUG 11 1966 25b REGISTRAR'S SIGNATURE Charles Judge	



10840

CERTIFICATE OF DEATH

10840

1. PLACE OF DEATH a. COUNTY ANNE ARUNDEL b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LINTHICUM HEIGHTS c. LENGTH OF STAY IN 1b LINTHICUM HEIGHTS d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 404 W. MAPLE ROAD		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY ANNE ARUNDEL c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LINTHICUM HEIGHTS d. STREET ADDRESS 404 W. MAPLE ROAD e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First TREVIA Middle E. Last FUGMAN		4. DATE OF DEATH Month AUGUST Day 29 Year 1966	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH SEPT. 26, 1899
9. AGE (In years last birthday) 66 yrs		10. IF UNDER 1 YEAR Months 6 Days 3 Hours 15 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY PENNSYLVANIA	
11. BIRTHPLACE (County & State or foreign country) PENNSYLVANIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME WILLIAM A. SLADE		14. MOTHER'S MAIDEN NAME JOSEPHINE ELDER	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO MRS. HELEN I. FUGMAN, 404 W. MAPLE ROAD	
17. INFORMANT MRS. HELEN I. FUGMAN, 404 W. MAPLE ROAD		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 416x DUE TO Cardiogenic h.t. failure Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO Rh incompatibility dis. (c) 30+ y.		INTERVAL BETWEEN ONSET AND DEATH 30+ y.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour of day 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Jan , 19 66 to 8/29 , 19 66 , that (I) (was) last saw the deceased alive on 8/29 , 19 66 and that death occurred at 7 A.M. from causes and on the date stated above.			
22a. SIGNATURE Christian S. Mass		22b. DATE SIGNED 8/30/66	
22c. PHYSICIAN'S NAME (Type) CHRISTIAN S. MASS MD.		22d. ADDRESS BALTO. NATIONAL PIKE & ST. JOHN'S LANE	
23a. BURIAL, CREMATION, REMOVAL (Type) BURIAL		23b. DATE THEREOF 9-1-66	
23c. NAME OF CEMETERY OR CREMATORY MEADOWRIDGE CEMETERY		23d. LOCATION (City or Town) (County) (State) BALTIMORE, MARYLAND	
24. FUNERAL DIRECTOR HOWARD H. HUBBARD FUNERAL HOME 4107 WILKENS AVE		25a. REC'D BY REGISTRAR AUG 31 1966	
25b. REGISTRAR'S SIGNATURE Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



10850

CERTIFICATE OF DEATH

10841

1. PLACE OF DEATH a COUNTY AnnaRundlie MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institut on. Residence before admission) a STATE SOUTH CAROLINA b COUNTY	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FT. MEADE, MD.		c LENGTH OF STAY in lb 12Hrs.	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospita give street address) Kimbrough Army Hosp. FGGM MD.		d STREET ADDRESS 103 Gardinia St.	
3 NAME OF DECEASED (Type or print) First Evla Middle Penny Last Fuller		4 DATE OF DEATH Month August Day 1 , Year 1966	
5 SEX F	6. COLOR OR RACE CAU.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH Sept. 7, 1894
9 AGE (in years last birthday) yrs. 71		IF UNDER 1 YEAR Months Days Hours Min.	
10a USUAL OCCUPATION (Give kind of work done during most of working life even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY none	
11 BIRTHPLACE (County & State, or foreign country) POLIN GEORGIA		12. CITIZEN OF WHAT COUNTRY? USA	
13 FATHER'S NAME John Franklin Hedge		14 MOTHER'S MAIDEN NAME Molly Burnett Edge	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16 SOCIAL SECURITY NO 259-62-9675	
17. INFORMANT Reba Lee Potter		1270 Enterprise Rd. Mitchellville, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myocardial Infarction DUE TO (b) Arteriosclerotic Heart Disease DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		INTERVAL BETWEEN ONSET AND DEATH 12hrs 20 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 1 Aug , 19 66 , to 1 Aug , 19 66 , that (I) (we) last saw the deceased alive on 1 Aug , 19 66 , and that death occurred at 3:30 PM , from causes and on the date stated above.			
22a. SIGNATURE Carl S. Rosen		22b. DATE SIGNED 1 Aug 66	
22c. PHYSICIAN'S NAME (Type) CARL S. ROSEN, CAPT, MC		22d. ADDRESS KIMBROUGH ARMY HOSPITAL, FGGMMD	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	8-4-66	New Georgia	New Georgia Georgia
24. FUNERAL DIRECTOR Will H. Hunsicker		25a. REC'D BY REGISTRAR Charles Judge	
25b. REGISTRAR'S SIGNATURE		DATE AUG 10 1966	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 5-63

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u>		2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission) e. STATE <u>MD.</u> b. COUNTY <u>Prince Georges</u>									
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie, Md</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Newark</u>									
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Therapeutic Nursing Home</u>		d. STREET ADDRESS <u>P.O. Box 72</u>									
3. NAME OF DECEASED (Type or print) First Middle Last <u>William Henry Garrison</u>		4. DATE OF DEATH Month Day Year <u>8 9 1966</u>									
5. SEX <u>M</u>		6. COLOR OR RACE <u>Negro</u>									
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>WIDOWED</u> <u>12-25-1895</u>		9. AGE (In years last birthday) <u>70</u> yrs. <table border="1"> <tr> <th colspan="2">IF UNDER 1 YEAR</th> <th colspan="2">IF UNDER 24 HRS.</th> </tr> <tr> <td>Months</td> <td>Days</td> <td>Hours</td> <td>Min.</td> </tr> </table>		IF UNDER 1 YEAR		IF UNDER 24 HRS.		Months	Days	Hours	Min.
IF UNDER 1 YEAR		IF UNDER 24 HRS.									
Months	Days	Hours	Min.								
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Food Work</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>unknown</u>									
11. BIRTHPLACE (County & State, or foreign country) <u>unknown</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>									
13. FATHER'S NAME <u>unknown</u>		14. MOTHER'S MAIDEN NAME <u>unknown</u>									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>unknown</u>		16. SOCIAL SECURITY NO. <u>24-32288</u>									
17. INFORMANT <u>Mrs. Frazier</u>		Address <u>Pharmacia</u>									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Occlusion</u> (b) <u>Religian of Hostate</u> (c) <u>Parkinson's Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> <u>unknown</u> <u>unknown</u>									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>									
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)									
21. I certify that (I) (this hospital) attended the deceased from <u>2-15</u> 19 <u>63</u> to <u>8-9</u> 19 <u>66</u> that (I) (we) last saw the deceased alive on <u>8-7</u> 19 <u>66</u> , and that death occurred at <u>12</u> M. from the causes and on the date stated above.											
22a. SIGNATURE <u>Richard H. Hunt</u>		22b. DATE SIGNED <u>100 Chem Lane, Glen Burnie, Md</u>									
22c. PHYSICIAN'S NAME (Type) <u>Richard H. Hunt</u>		22d. ADDRESS									
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>8-13-66</u>									
23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Chapel</u>		23d. LOCATION (City, town or county) (State) <u>Newark, Maryland</u>									
24. FUNERAL DIRECTOR'S SIGNATURE <u>Loretta B. Jolley - Jersey City, N.J.</u>		25a. REC'D BY REGISTRAR <u>DATE AUG 11 1966</u>									
25b. REGISTRAR'S SIGNATURE <u>working judge</u>											

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/66

10852

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10843

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

1 PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2 USUAL RESIDENCE (Where deceased lived if inst. tuton Res dence before admiss on) a. STATE D. C. b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) urial, Glen Burnie		c. LENGTH OF STAY IN lb x	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Mountain Road and Ritchie Highway		e. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) Washington	
3 NAME OF DECEASED (Type or print) Raymond A Gemmill		4. DATE OF DEATH Month Aug. Day 27 Year 1966	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug 18, 1886
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MACHINIST (RETIRED)		10b. KIND OF BUSINESS OR INDUSTRY U.S. NAVY YARD	9. AGE (In years last birthday) yrs 80
11. BIRTHPLACE (State or foreign country) York County, PENNA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JAMES BRYAN GEMMILL		14. MOTHER'S MAIDEN NAME GUSTINA RENFREW	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) NO		16. SOCIAL SECURITY NO 578-38-8624	
17. INFORMANT ELIZABETH S. GEMMILL		Address WASH. D.C. - 1827-9th St SE.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) DUE TO Multiple contusions, lacerations, and fractures incurred when hit by a car at Mountain Road and Ritchie Highway. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c)		INTERVAL BETWEEN ONSET AND DEATH immediate	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) none		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) He was walking across the road when he was hit by a car	
20c. TIME OF INJURY Month, Day Year 8:45 PM 19	20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input checked="" type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) Street	
20f. (City or town) (County) (State) Glen Burnie, A.A. Md.			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Charles H. Wirth, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town or county)	
EXAMINER'S NAME (Type) Charles H. Wirth, M.D.		8/27/66 DATE SIGNED	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF Aug. 31/66	23c. NAME OF CEMETERY OR CREMATORY FORT LINCOLN COM	23d. LOCATION (City or Town) (County) (State) COLUMBIA MARYLAND
24. FUNERAL DIRECTOR W.W. CHAMBERS Co - WASH. D.C.		25a. REC'D BY REGISTRAR DATE AUG 30 1966	
		25b. REGISTRAR'S SIGNATURE Charles Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

10853

10844

1. PLACE OF DEATH a. COUNTY AA MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Virginia b. COUNTY _____	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fleming		c. LENGTH OF STAY IN ID _____	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) North Arnold Hospital		d. STREET ADDRESS RT 1 Box 80 Fairfax Station Va	
3. NAME OF DECEASED (Type or print) First JAMES Middle E Last GIBSON		4. DATE OF DEATH Month 8 Day 27 Year 1966	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 3-5-05
9. AGE (In years last birthday) 61 yrs.		10. IF UNDER 1 YEAR Months _____ Days _____ IF UNDER 24 HRS. Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Truck -		10b. KIND OF BUSINESS OR INDUSTRY _____	
11. BIRTHPLACE (County & State, or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. _____	
17. INFORMANT		Address _____	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myocardial infarction Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic heart disease DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			INTERVAL BETWEEN ONSET AND DEATH 3 days
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 8/24 , 19 66 , to 8/27 , 19 66 , that (I) (we) last saw the deceased alive on 8/26 , 19 66 , and that death occurred at 5:15 M, from the causes and on the date stated above.			
22a. SIGNATURE J. B. Ramire		22b. DATE SIGNED 8/27/66	
22c. PHYSICIAN'S NAME (Type) J. B. RAMIRE MD		22d. ADDRESS 3927 ANNAPOLIS RD Baltimore 27 Md 1672 NORTHBOURNE RD Baltimore 1 Md	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF 8-29-66	23c. NAME OF CEMETERY OR CREMATORY W. of Md. Med. School	23d. LOCATION (City, town or county) (State) Baltimore, Md.
24. FUNERAL DIRECTOR		25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE Charles Judge	
DATE AUG 31 1966			



10854

CERTIFICATE OF DEATH

10845

1 PLACE OF DEATH a. COUNTY Anne Arundel		b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Annapolis		c. LENGTH OF STAY IN 1b D. O. A.		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland		b. COUNTY Anne Arundel	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Anne Arundel General Hospital		e. STREET ADDRESS 4 Beach Road P. O. Box 596		f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3 NAME OF DECEASED (Type or print) Arthur		4 DATE OF DEATH August		5 SEX Male		6 COLOR OR RACE White		7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	
8 BIRTHPLACE (County & State or foreign country) England		9 AGE (In years last birthday) 68		10a. USUAL OCCUPATION (Give kind of work done during most of work in life, even if retired) Developer, Land Real Estate		10b. KIND OF BUSINESS OR INDUSTRY Real Estate		11 BIRTHPLACE (County & State or foreign country) England	
12 CITIZEN OF WHAT COUNTRY? U. S.		13 FATHER'S NAME Thomas A. Giddings		14 MOTHER'S MAIDEN NAME Ann Giddings		15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16 SOCIAL SECURITY NO 214540847	
17 INFORMANT Lydia Giddings		18 ADDRESS Above		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Coronary Thrombosis DUE TO (b) Hypertension CVD & DUE TO (c) Arteriosclerotic CVD		INTERVAL BETWEEN ONSET AND DEATH 8 years							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Pericarditis		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) XXXXXX attended the deceased from Jan , 19 65 , to 8-4-66 , that (I) was last saw the deceased alive on 7-14-66 , and that death occurred at 8:06 A. M. , from causes and on the date stated above.		22a. SIGNATURE Frank M. Shipley		22b. ADDRESS 121 Cathedral St., Annapolis, Md.		22c. DATE SIGNED 8-4-66			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 8-8-66		23c. NAME OF CEMETERY OR CREMATORY Meadowridge Cem		23d. LOCATION (City or Town) (County) (State) Dorsey, Md.			
24. FUNERAL DIRECTOR Robert S. Banana		25a. REC'D BY REGISTRAR DATE AUG 9 1966		25b. REGISTRAR'S SIGNATURE Charles Judge					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

CERTIFICATE OF DEATH

10855

10846

1. PLACE OF DEATH a. COUNTY <u>ANNE ARUNDEL</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>ANNE ARUNDEL</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Edgewater, Md</u>	
c. LENGTH OF STAY IN <u>2 weeks</u>		d. STREET ADDRESS <u>Rte 1 Box 256</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>AA General</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Peter Paul GRANICKAS</u>	First Middle Last	4. DATE OF DEATH <u>Aug 28</u> 19 <u>66</u>	Month Day Year
5. SEX <u>Male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct 31, 1892</u>
9. AGE (In years last birthday) <u>73</u> yrs.		10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Book binder</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Book maker</u>	11. BIRTHPLACE (County & State, or foreign country) <u>LITHUANIA</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>unknown</u>		14. MOTHER'S MAIDEN NAME <u>unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)		16. SOCIAL SECURITY NO. <u>139-09-1324</u>	
17. INFORMANT <u>Agnes Roe Rte 1 Box 256 Edgewater, Md</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Pneumonia</u>			
(b) <u>Generalized atherosclerosis</u>			
(c) <u>unknown</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>unknown</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>8/14</u> 19 <u>66</u> to <u>8/28</u> 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>8/27</u> 19 <u>66</u> , and that death occurred at <u>7:30</u> AM, from the causes and on the date stated above			
22a. SIGNATURE <u>Richard I. Hochman</u> M.D.		22b. DATE SIGNED <u>8/28/66</u>	22c. PHYSICIAN'S NAME (Type) <u>Richard I. Hochman</u>
22d. ADDRESS <u>59 Franklin St. Annapolis, Md</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY <u>St Johns</u>	23d. LOCATION (City, town or county) (State) <u>Long Island, N.Y.</u>
24. FUNERAL DIRECTOR'S SIGNATURE <u>T A Hardisty</u> ADDRESS <u>12 Ridgely Ave Annapolis, Md</u>		25a. REC'D BY REGISTRAR <u>g Charles Judge</u>	25b. REGISTRAR'S SIGNATURE
DATE <u>AUG 31 1966</u>			

MEDICAL CERTIFICATION

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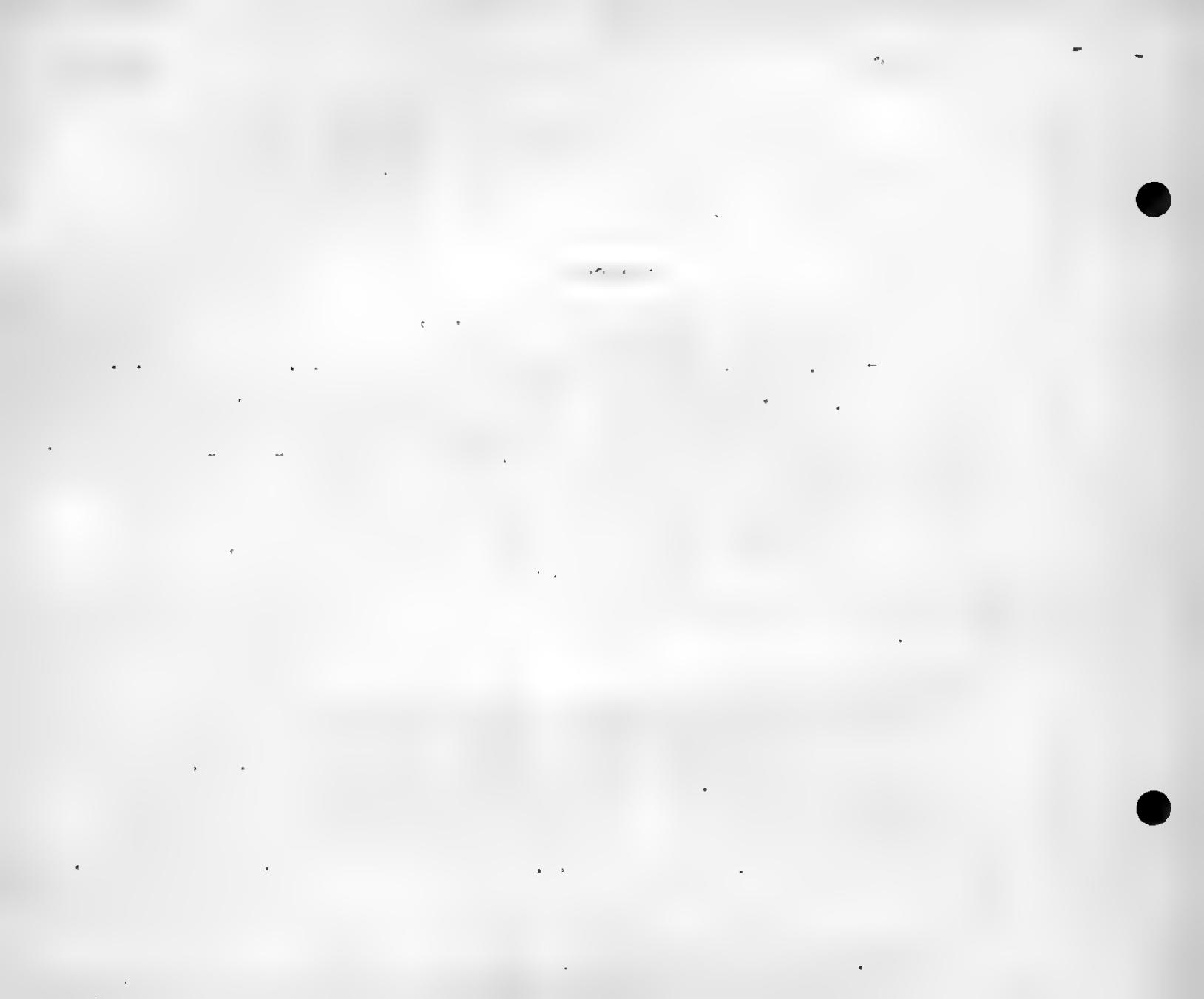
10855

CERTIFICATE OF DEATH

10847

1 PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institut on: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. LENGTH OF STAY IN lb 7 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Anne Arundel General Hospital		e. STREET ADDRESS Box-113	
3 NAME OF DECEASED (Type or print) William Frances GRAVES		4. DATE OF DEATH Month August Day 22 Year 19 66	
5 SEX Male	6 COLOR OR RACE White	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 2, 1897
9 AGE (In years lost birthdaoy) yrs 69		F UNDER 1 YEAR Months 7 Days 20 IF UNDER 24 HRS Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired - Dist. of Col. Police Force		10b. KIND OF BUSINESS OR INDUSTRY Washington, D.C.	
11 BIRTHPLACE (County & State or foreign country) U.S.		12 CITIZEN OF WHAT COUNTRY? U.S.	
13 FATHER'S NAME William E. Graves		14 MOTHER'S MAIDEN NAME Mary Catherine Carroll	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) Yes WWI		16 SOCIAL SECURITY NO. Unknown	
17 INFORMANT M. Catherine Graves-Wife-Same Item #2		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Pulmonary edema 4201 DUE TO Lower nephron-neparosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Severe Coronary (c) arteriosclerosis			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) signed colon valvulus			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (the hospital) attended the deceased from 19 to Aug. 22, 1966 , that (I) (the hospital) saw the deceased alive on Aug. 22 19 66 , and that death occurred at M , from causes and on the date stated above			
22a. SIGNATURE Stephen B. Hiltabidle		22b. DATE SIGNED 8-23-66	
22c. PHYSICIAN'S NAME (Type) Stephen B. Hiltabidle, M.D.		22d. ADDRESS 121 Cathedral St., Annapolis, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 8/26/1966	23c. NAME OF CEMETERY OR CREMATORY Arlington National	23d. LOCATION (City or Town) (County) (State) Arlington Virginia
24. FUNERAL DIRECTOR Robert A. Pumphrey		25a. REC'D BY REGISTRAR Bethesda, Maryland	
25b. REGISTRAR'S SIGNATURE DATE AUG 25 1966		J. Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10857

CERTIFICATE OF DEATH

10848

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. LENGTH OF STAY IN 1b 10 days	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Galesville
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Anne Arundel General Hospital		d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Frances Middle Ann Last GROSS		4. DATE OF DEATH Month August Day 8 Year 1966	
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 9, 1900
9. AGE (In years last birthday) yrs. 66		10. IF UNDER 1 YEAR: Months 0 Days 0 IF UNDER 24 HRS. Hours 0 Min 0	
10a. USUAL OCCUPATION (Give kind of work done during part of working life, even if retired) Maid		10b. KIND OF BUSINESS OR INDUSTRY Housework	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Samuel Neal		14. MOTHER'S MAIDEN NAME Mama R. Tydings	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 217303588	
17. INFORMANT Thomas Gross		Address Galesville, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 205X DUE TO Uremia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Multiple myeloma DUE TO (c) 18 months			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVA. BETWEEN ONSET AND DEATH			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) Willard F. Smith attended the deceased from Jan. 1967 to Aug. 8, 1966 that (I) was last saw the deceased alive on Aug. 8, 1966 , and that death occurred at 1:15 PM M. from causes and on the date stated above.			
22a. SIGNATURE Willard F. Smith		22b. DATE SIGNED 8/8/66	
22c. PHYSICIAN'S NAME (Type) Willard F. Smith, M.D.		22d. ADDRESS Shady Side, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Buried	23b. DATE THEREOF 8-11-1966	23c. NAME OF CEMETERY OR CREMATORY Cherry Memorial	23d. LOCATION (City or Town) (County) (State) Galesville, Md.
24. FUNERAL DIRECTOR William Reese H. Annand		25a. REC'D BY REGISTRAR AUG 10 1966	
		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

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VR A15ME (5-1)
6M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10858

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10849

1 PLACE OF DEATH a. COUNTY <u>A.A. Co.</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>AAO.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson - Glen Burnie</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson -</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>D.O.A. - North. ACUMBEL - No. p.</u>		e. STREET ADDRESS <u>119 Brookview Ke</u>	
3 NAME OF DECEASED (Type or print) <u>Joseph L. GRUNINGER</u>		4. DATE OF DEATH Month <u>8</u> Day <u>8</u> Year <u>1966</u>	
5 SEX <u>M</u>	6 COLOR OR RACE <u>W</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>9-1-02</u>
9 AGE (In years last birthday) <u>63</u> YRS		10 IF UNDER 1 YEAR Months <u>1</u> Days <u>24</u> Hrs <u>0</u> Min <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Salvage</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>New Jersey</u>	
11 BIRTHPLACE (State or foreign country) <u>New Jersey</u>		12 CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13 FATHER'S NAME <u>GRUNINGER</u>		14 MOTHER'S MAIDEN NAME <u>UNKNOWN</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16 SOCIAL SECURITY NO <u>177-20-0552</u>	
17 INFORMATION <u>Louis Bracato</u>		Address <u>476 Ruby Ave</u>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cardiac disease</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>1944</u> DUE TO (c) <u>Arteriosclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>Arteriosclerosis</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour <u>0</u> min <u>0</u> pm <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>E. Linhart</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>E. Linhart</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
		Address (Street, city, town or county) <u>8/8/66</u>	
23a. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>8-13-66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u>	23d. LOCATION (City or Town) (County) (State) <u>Baltimore Md</u>
24 FUNERAL DIRECTOR <u>GERTRUDE KENNY</u>		ADDRESS <u>5646 Crockett</u>	
25a. REC'D BY REGISTRAR <u>Charles Judge</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	
DATE <u>AUG 15 1966</u>			

FOR STATE HEALTH DEPT.

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VR A15ME (5)
6M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10850

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10850

1 PLACE OF DEATH a. COUNTY <u>AA Co.</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>19. A. Co.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ANNAPOLIS</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Deale</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>D.O.A. - ANNE ARUNDEL - GENERAL</u>		e. STREET ADDRESS	
3 NAME OF DECEASED (Type or print) First <u>Nettie</u> Middle <u>M</u> Last <u>904</u>		4 DATE OF DEATH Month <u>8</u> Day <u>9</u> Year <u>1966</u>	
5 SEX <u>F</u>	6 COLOR OR RACE <u>W.</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>4-19-93</u>
9 AGE (In years last birthday) <u>73</u> yrs.		10 F UNDER 1 YEAR Months <u>1</u> Days <u>1</u> Hours <u>1</u> Min <u>1</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11 BIRTHPLACE (State or foreign country) <u>Tennessee</u>		12 CITIZENSHIP OF WHAT COUNTRY? <u>USA</u>	
13 FATHER'S NAME <u>Charles Justin McMurtry</u>		14 MOTHER'S MAIDEN NAME <u>Mary Cornell</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>—</u>		16 SOCIAL SECURITY NO. <u>218240561</u>	
17 INFORMANT <u>Luther S. Fry, Deale, Md.</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Ortokeriosis generalisata</u> DUE TO (b) <u>—</u> DUE TO (c) <u>—</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost		INTERVAL BETWEEN ONSET AND DEATH <u>—</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u>—</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>E. Linhardt</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>E. Linhardt</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
		Address (Street, city, town, or county) <u>8-5-CC</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>8-12-66</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Burlington National</u>		23d. LOCATION (City or Town) (County) (State) <u>Burlington Md.</u>	
24. FUNERAL DIRECTOR <u>Bernard Hardisty</u>		25. REC'D BY REGISTRAR <u>Charles Judge</u>	
ADDRESS <u>Galesville, Md.</u>		DATE <u>AUG 18 1966</u>	



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10860

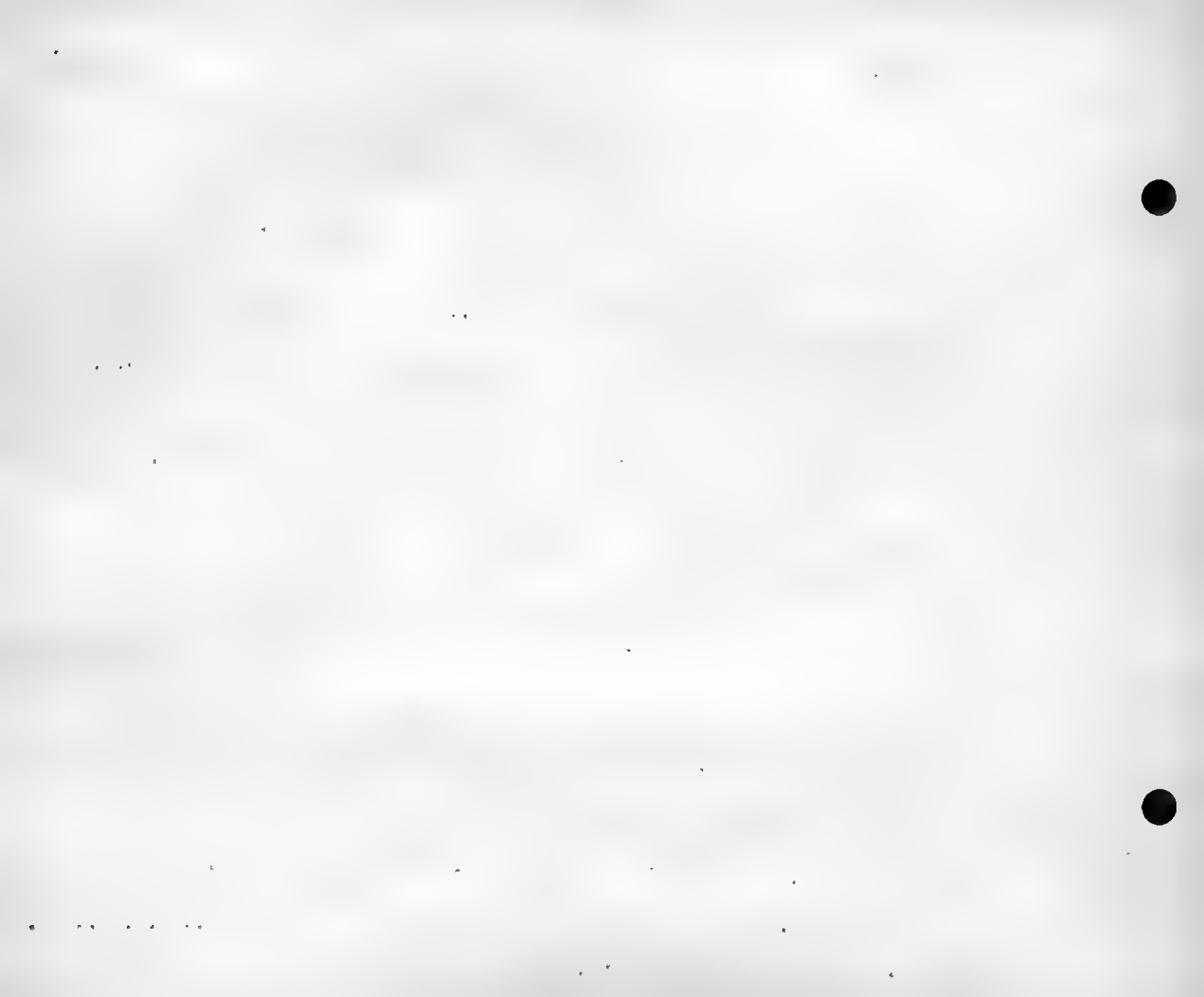
CERTIFICATE OF DEATH

10851

1 PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institut an Residence before admision) a STATE Maryland b COUNTY	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Millersville		c LENGTH OF STAY IN lb 4 months	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Knollwood Nursing Home		d. STREET ADDRESS 5 Patapsco Rd.	
3 NAME OF DECEASED (Type or print) Isabelle (Belle) Haberkorn		4. DATE OF DEATH Month 8 Day 15 Year 1966	
5 SEX F	6 COLOR OR RACE W	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Apr., 1884
9 AGE (In years lost birthday) 82 yrs		10 IF UNDER 1 YEAR Months 8 Days 15 Hours 19 Min.	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b KIND OF BUSINESS OR INDUSTRY Maryland	
11 BIRTHPLACE (County & State, or foreign country) U.S.		12 CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME --- Adams		14. MOTHER'S MAIDEN NAME ----	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO ----	
17. INFORMANT August Haberkorn - 3012 Ohio Ave., Baltimore		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) acute myocardial infarction 42.11 DUE TO (b) coronary occlusion Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) arteriosclerosis		INTERVAL BETWEEN ONSET AND DEATH 1 day	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) osteoporosis		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 6/2 , 19 66 , to 8/15 , 1966, that (I) (we) last saw the deceased alive on 8/15 , 19 66 , and that death occurred at 8:30 AM, from causes and on the date stated above.			
22a. SIGNATURE Ray M. Smith		22b. DATE SIGNED 8/15/66	
22c. PHYSICIAN'S NAME (Type) Ray M. Smith, M.D.		22d. ADDRESS Hahn Professional Bldg. Severna Park, Md.	
23a BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Aug. 18, 1966	
23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		23d. LOCATION (City or Town) (County) (State) Ritchie Hwy., A.A. Co., Md.	
24. FUNERAL DIRECTOR George J. Gonce, 4001 Ritchie Hwy., Baltimore		25. READ BY REGISTRAR AUG 17 1966	
25b. REGISTRAR'S SIGNATURE Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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CERTIFICATE OF DEATH

10852

10862

1. PLACE OF DEATH a. COUNTY Anne Arundel b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis c. LENGTH OF STAY IN 1b Annopolis		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis	
3. NAME OF DECEASED (Type or print) First Middle Last Howard Victor HALL		4. DATE OF DEATH Month Day Year August 24 1966	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 25, 1900
9. AGE (In years last birthday) 66 yrs		10. IF UNDER 1 YEAR Months Days Hours Min 24 19 66	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Dental Surgeon		12. KIND OF BUSINESS OR INDUSTRY Dentistry	
13. BIRTHPLACE (County & State, or foreign country) New York		14. CITIZEN OF WHAT COUNTRY? U.S.	
15. FATHER'S NAME Howard Victor A. Hall		16. MOTHER'S MAIDEN NAME Grace Brooks	
17. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) No		18. SOCIAL SECURITY NO Velma R. Hall	
19. INFORMANT Velma R. Hall		Address #2	
19. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cardiac arrest Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 1200 DUE TO (b) Arteriosclerotic Heart Disease DUE TO (c) Unknown		INTERVAL BETWEEN ONSET AND DEATH Immediate	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (the hospital) attended the deceased from 12/4, 1963 , to 8/24, 1966 , that (I) (we) last saw the deceased alive on 8/24, 1966 , and that death occurred at 4:45 PM , from causes and on the date stated above.			
22a. SIGNATURE Richard I. Hochman, M.D.		22b. DATE SIGNED 8/25/66	
22c. PHYSICIAN'S NAME (Type) Richard I. Hochman, M.D.		22d. ADDRESS 59 Franklin St., Annapolis, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF 3-27-1966	23c. NAME OF CEMETERY OR CREMATORY St. Anne's	23d. LOCATION (City or Town) (County) (State) Annapolis Md.
24. FUNERAL DIRECTOR John M. Taylor & Sons		25a. REC'D BY REGISTRAR DATE AUG 29 1966	25b. REGISTRAR'S SIGNATURE J. Charles Jones

MEDICAL CERTIFICATION

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1000



FOR STATE
HEALTH-DEPT.

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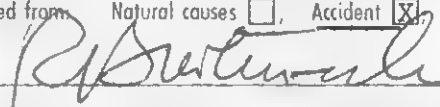
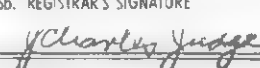
MARYLAND STATE DEPARTMENT OF HEALTH

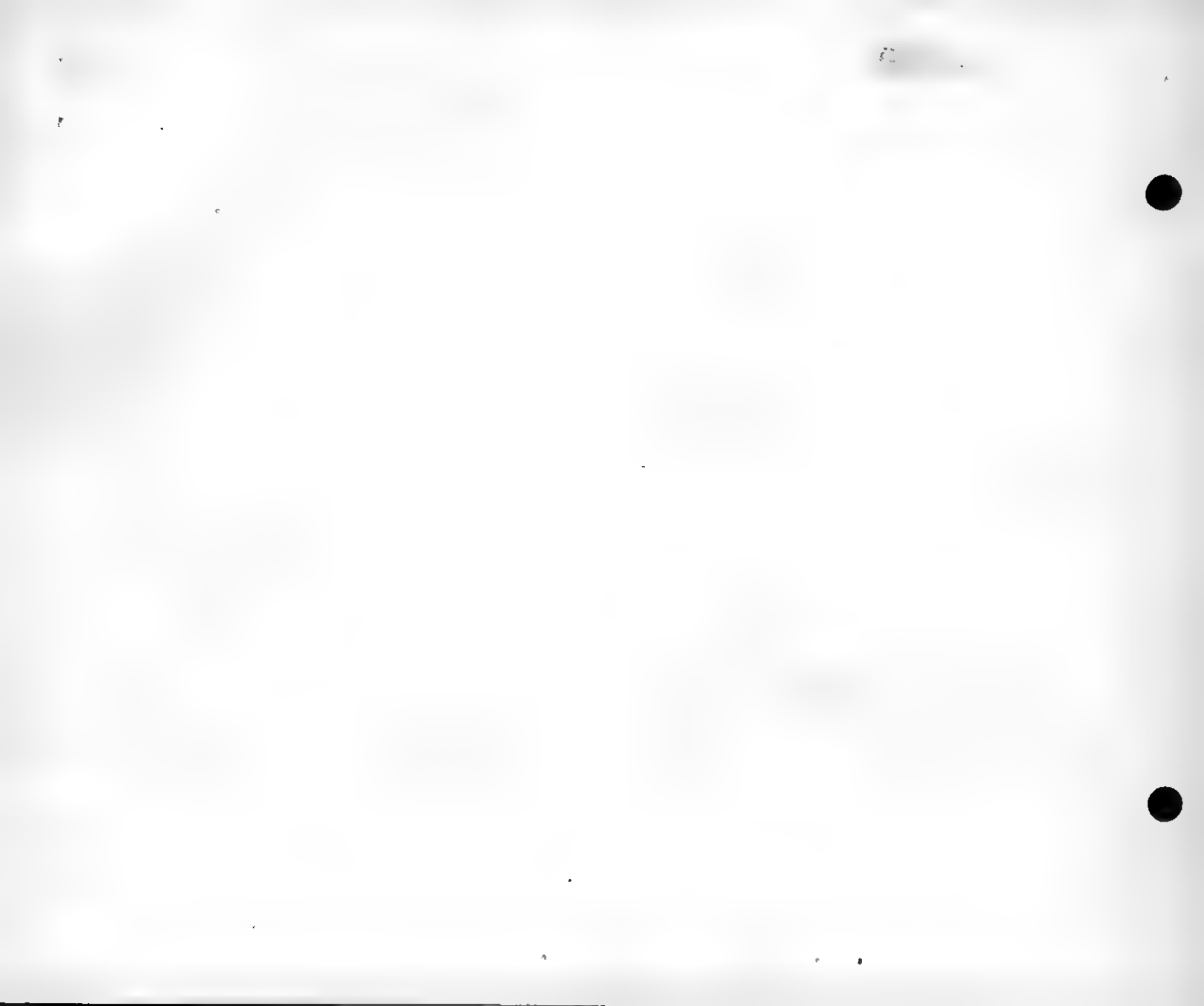
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10863

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10854

1 PLACE OF DEATH a. COUNTY ANNE ARUNDEL MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie			c. LENGTH OF STAY in 1b			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pasadena	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) North Arundel General Hospital				d. STREET ADDRESS 109 S. Carolina Av. Pasadena, Md.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First Middle Last JOSEPH P. HARGETT				4 DATE OF DEATH Month Day Year 8 14 19 66			
5 SEX Male	6 COLOR OR RACE White	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 1-9-46		9 AGE (In years last birthday) 20 yrs	IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Balto., Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME James Hargett				14. MOTHER'S MAIDEN NAME Ellen Stevenson			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO 212-46-8275		17. INFORMANT Mrs. Ellen Hargett 100 S. Carolina Ave., XXX		21142	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Crushing chest injuries DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) _____ DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Passenger in auto into fixed object					
20c. TIME OF INJURY Month, Day, Year Hour a.m. 2:45 8 14 19 66		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input checked="" type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Highway		20f. (City or town) (County) (State) Pinehurst Road Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE  EXAMINER'S NAME (Type) RUDIGER BREITENECKER, M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> Address (Street city, town, or county) Balto., Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 8-17-66		23c. NAME OF CEMETERY OR CREMATORY New Cathedral		23d. LOCATION (City or Town) (County) (State) Balto., Md.	
24. FUNERAL DIRECTOR Witzke F. D. 4101 Edmondson Av.				25a. REC'D BY REGISTRAR AUG 16 1966		25b. REGISTRAR'S SIGNATURE 	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
15M 4-64

<div style="display: flex; justify-content: space-between;"> <div> <p>MARYLAND STATE DEPARTMENT OF HEALTH</p> <p>DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</p> <p>10864</p> </div> <div> <p>CERTIFICATE OF DEATH</p> </div> <div> <p>10855</p> </div> </div>											
<p>1. PLACE OF DEATH</p> <p>a. COUNTY <u>Anne Arundel</u> MARYLAND</p> <p>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Brooklyn Park</u></p> <p>c. LENGTH OF STAY IN 1b <u>9 months</u></p> <p>d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>502 Church St.</u></p>						<p>2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)</p> <p>a. STATE <u>Maryland</u> b. COUNTY <u>Talbot</u></p> <p>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Tilghman</u></p> <p>d. STREET ADDRESS</p> <p>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></p>					
<p>3. NAME OF DECEASED (Type or print)</p> <p>First <u>REKTHA</u> Middle <u>A.</u> Last <u>HARRISON</u></p>						<p>4. DATE OF DEATH</p> <p>Month <u>Aug</u> Day <u>27</u> Year <u>1966</u></p>					
<p>5. SEX <u>FEMALE</u></p>		<p>6. COLOR OR RACE <u>W</u></p>		<p>7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/></p>		<p>8. DATE OF BIRTH <u>Aug. 4, 1894</u></p>		<p>9. AGE (In years last birthday) <u>72</u> yrs.</p>		<p>IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u></p>	
<p>10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u></p>				<p>10b. KIND OF BUSINESS OR INDUSTRY</p>		<p>11. BIRTHPLACE (County & State, or foreign country) <u>Talbot - Maryland</u></p>		<p>12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u></p>			
<p>13. FATHER'S NAME <u>Emil Scharch</u></p>						<p>14. MOTHER'S MAIDEN NAME <u>MARY N. Blitt</u></p>					
<p>15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service)</p>				<p>16. SOCIAL SECURITY NO. <u>219-05-1229</u></p>		<p>17. INFORMANT <u>Mrs. Iva Rardoe</u> Address <u>502 Church St. Brooklyn Park Md.</u></p>					
<p>18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]</p> <p>PART I. DEATH WAS CAUSED BY:</p> <p>IMMEDIATE CAUSE (a) <u>Metastatic Carcinoma Bone</u></p> <p>Conditions. If any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>CARCINOMA BREAST</u></p> <p>DUE TO (c) <u> </u></p> <p>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)</p> <p>INTERVAL BETWEEN ONSET AND DEATH <u>6 mos</u></p> <p>7 yrs</p>											
<p>19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/></p>											
<p>20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</p>						<p>20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)</p>					
<p>20c. TIME OF INJURY Month, Day, Year</p> <p>Hour a.m. <u> </u> p.m. <u>19</u></p>				<p>20d. INJURY OCCURRED</p> <p>While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work <input type="checkbox"/></p>		<p>20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)</p>		<p>20f. (City or town) (County) (State)</p>			
<p>21. I certify that (I) (this hospital) attended the deceased from <u>1/5</u>, 19<u>66</u>, to <u>8/27</u>, 19<u>66</u>, that (I) (we) last saw the deceased alive on <u>8/27</u>, 19<u>66</u>, and that death occurred at <u>4 PM</u>, from the causes and on the date stated above.</p>											
<p>22a. SIGNATURE <u>Benjamin Berdann</u></p>						<p>22b. DATE SIGNED <u>8/29/66</u></p>					
<p>22c. PHYSICIAN'S NAME (Type) <u>Benjamin Berdann, M.D.</u></p>						<p>22d. ADDRESS <u>5010A Ritchie Highway #25</u></p>					
<p>23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u></p>				<p>23b. DATE THEREOF <u>Aug. 30, 1966</u></p>		<p>23c. NAME OF CEMETERY OR CREMATORY <u>Tilghman Methodist</u></p>		<p>23d. LOCATION (City, town or county) (State) <u>Tilghman Maryland</u></p>			
<p>24. FUNERAL DIRECTOR <u>Lickmore Tilghman M.D.</u></p>						<p>25a. REC'D BY REGISTRAR <u>SEP 2 1966</u> 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u></p>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. This page should be removed from the certificate and in any event, within 72 hours after death.

10862

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

10853

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>M.D.</u> b. COUNTY <u>A.A.</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>ARND</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Box 81 Rt 3</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>St. Margaret's</u>		d. STREET ADDRESS <u>Arnd</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Henry Lewis Hawks</u>		4. DATE OF DEATH <u>8-28-66</u> 19 <u>66</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-3-1885</u>
9. AGE (In years last birthday) <u>81</u> yrs.		10. IF UNDER 1 YEAR: Months <u>8</u> Days <u>19</u> Hours <u>19</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Assistant Engineer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Ret.</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Annapolis Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Maxwell H. Hawks</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth E. Hawk</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>ST. MARGARETS</u>	
17. INFORMANT <u>MRS. JAMES VAUSANT A.A. Co. MD.</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): <u>Leukemia</u> DUE TO <u>Gen. airt.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>1956</u> , 19 <u>56</u> , to <u>1966</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>8-27-66</u> 19 <u>66</u> , and that death occurred at <u>3:30</u> AM, from the causes and on the date stated above.			
22a. SIGNATURE <u>Robert R. Hahn</u>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>Robert R. HAHN</u>		22d. ADDRESS <u>P.O. Box 73 Severna Park</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>8-30-66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>ST. MARGARETS CEM</u>	23d. LOCATION (City, town or county) (State) <u>A.A. Co. MD</u>
24. FUNERAL DIRECTOR <u>JOHN M. TAYLOR. SONS ANNAPOLIS MD</u>		25a. REC'D BY REGISTRAR <u>Aug 31 1966</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles J. Jager</u>			

200



FOR STATE
HEALTH DEPT.

10865

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10850

1 PLACE OF DEATH a. COUNTY ANNE ARUNDEL MARYLAND			2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Washington, D.C. b. COUNTY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural, near Bristol		c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) District Heights		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Anne Arundel General Hospital (DOA)			d. STREET ADDRESS 7927 District Heights		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3 NAME OF DECEASED (Type or print) RANDOPH	First G.	Middle HEFLIN	Last HEFLIN	4 DATE OF DEATH Month August Day 28 Year 19 66	
5 SEX Male	6 COLOR OR RACE White	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 1/21/44	9 AGE (In years last birthday) 22 yrs	10 UNDER 1 YEAR Months 22 Days 22 Hours 22 Min 22
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Shoe Salesman		10b. KIND OF BUSINESS OR INDUSTRY		11 BIRTHPLACE (State or foreign country) Washington D. C.	
12 CITIZEN OF WHAT COUNTRY? USA			13 FATHER'S NAME Randolph G. Heflin		
14 MOTHER'S MAIDEN NAME Mary K. Savage			15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		
16 SOCIAL SECURITY NO			17 INFORMANT Francis Fletcher 7927 Dist. Hgts. Parkway Md.		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebrocranial injury DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					INTERVAL BETWEEN ONSET AND DEATH
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) Driver of auto which hit a utility pole and overturned		
20c. TIME OF INJURY Month, Day, Year 2:00 pm 8-28 19 66		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office, b.d., etc.) street	
20f. (City or town) Bristol		20g. (County) A.A.		20h. (State) Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from. Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE Charles S. Springate M.D.			22. DATE SIGNED August 29, 1966		
EXAMINER'S NAME (Type) Charles S. Springate, M.D.			DEPUTY MEDICAL EXAMINER <input type="checkbox"/> Address (Street, city, town, or county)		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 8/31/66		23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery	
23d. LOCATION (City or Town) Prince Georges, Maryland		23e. (County) Prince Georges		23f. (State) Md.	
24 FUNERAL DIRECTOR Wilhelm Funeral Home Address 4308 Suitland Rd. Suitland Md. 20023			25a. REC'D BY REGISTRAR DATE SEP 1 1966		
25b. REGISTRAR'S SIGNATURE Charles Judge			25c. REGISTRAR'S SIGNATURE		

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in transit within 72 hours after death.

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10866

10857

1 PLACE OF DEATH a. COUNTY AA CO MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE MD b. COUNTY AA CO	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie		c. LENGTH OF STAY IN IB	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) D.O.A. - NORTH ARUNDEL		e. STREET ADDRESS Clearwater Beach - Bldg 26	
3 NAME OF DECEASED (Type or print) First Leroy Middle M. Last Helm		4 DATE OF DEATH Month 8 Day 12 Year 1966	
5 SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH DEC 28 - 1898
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) pipe fitter		10b. KIND OF BUSINESS OR Md Dry	
11 BIRTHPLACE (State or foreign country) Penna		12 CITIZEN OF WHAT COUNTRY? USA	
13 FATHER'S NAME John Helms		14. MOTHER'S MAIDEN NAME Katherine Moats	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO	
17 INFORMANT Family		Address Same	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Arteriosclerosis generalized DUE TO (b) Sudden Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE E. L. Hubbard M.D.		22. DATE SIGNED 8/12/66	
EXAMINER'S NAME (Type) E. L. Hubbard		Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF 8/17/66	23c. NAME OF CEMETERY OR CREMATORY Glen Haven Cem	23d. LOCATION (City or Town) (County) (State) Glen Burnie MD
24 FUNERAL DIRECTOR McCully FH 237 Patapsco Ave 21225		25a. REC'D BY REGISTRAR AUG 18 1966	
		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
 20M 5-63

MEDICAL CERTIFICATION

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
<div style="display: flex; justify-content: space-between;"> 10867 CERTIFICATE OF DEATH 10858 </div>											
1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Anne Arundel</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Clearwater Beach</u>						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Clearwater Beach, Md</u>					
c. LENGTH OF STAY IN b. <u>10</u>						d. STREET ADDRESS <u>8209 Parkway Drive</u>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>North Arundel Gen Hosp</u>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <u>Otis S. Hitt</u>						4. DATE OF DEATH <u>August 8, 1966</u> 19 <u>19</u>					
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH <u>June 29, 1901</u>		9. AGE (In years last birthday) <u>65</u> yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS.	
				WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>						Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Tree Surgeon Balto City</u>						10b. KIND OF BUSINESS OR INDUSTRY <u>Elkton, Va</u>					
11. BIRTHPLACE (County & State, or foreign country) <u>U.S.</u>						12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>					
13. FATHER'S NAME <u>Middleton Hitt</u>						14. MOTHER'S MAIDEN NAME <u>Annie Shipley</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>						16. SOCIAL SECURITY NO. <u>?</u>					
17. INFORMANT <u>Margaret M. Hitt</u>						Address <u>8209 Parkway Drive, # 26</u>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Myocardial infarction</u>											
DUE TO <u>Coronary occlusion</u>											
DUE TO <u>Arteriosclerotic cardiovascular disease</u>											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)											
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
				20f. (City or town) (County) (State)							
21 I certify that (I) (this hospital) attended the deceased from <u>6-30, 1958</u> to <u>8-8, 1966</u> , that (I) (we) last saw the deceased alive on <u>6-1, 1966</u> and that death occurred at <u>12:45</u> PM, from the causes and on the date stated above.											
22a. SIGNATURE <u>Alfred G. Ossman Jr MD</u>						22b. DATE SIGNED					
22c. PHYSICIAN'S NAME (Type) <u>Alfred G. Ossman Jr MD</u>						22d. ADDRESS <u>1010 St Paul St Balto 2 MD</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				23b. DATE THEREOF <u>8/11/66</u>				23c. NAME OF CEMETERY OR CREMATORY <u>Meadowridge Memorial</u>			
								23d. LOCATION (City, town or county) (State) <u>Wash, Blvd. Md</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>Austin E. Donovan</u>						25a. REC'D BY REGISTRAR <u>Charles Judge</u>					
ADDRESS <u>3815 Roland Ave</u>						DATE <u>AUG 11 1966</u>					

FOR STATE
HEALTH DEPT.

10868

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10859

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 8. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 PLACE OF DEATH a COUNTY ANNE ARUNDEL MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institut an Residence before adm ssion) b STATE Maryland c COUNTY Queen Anne			
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ANNAPOLIS				c LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) ANNE ARUNDEL GENERAL HOSPITAL				d STREET ADDRESS			
3. NAME OF DECEASED (Type or print) First Middle Last WILLIAM JAMES HOLLINGSWORTH				4. DATE OF DEATH Month Day Year 8 23 1966			
5 SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> W DOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8 DATE OF BIRTH 2-2-48	
9 AGE (In years last birthday) 18 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS Hours Min			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) GAS STATION ATTENDANT				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND	
12 CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME WM. JAMES HOLLINGSWORTH				14. MOTHER'S MAIDEN NAME VIOLA EDGE MD.			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)				16. SOCIAL SECURITY NO			
17. INFORMANT W. J. HOLLINGSWORTH-STEVENSVILLE				Address			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Shotgun wound of chest DUE TO (b) DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) Apparently shot self			
20c. TIME OF INJURY Month Day Year Hour xxxx 8:00 p.m. 8 23 1966				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home	
20f. (City or town) Stevensville				20g. (County) Q. A.		20h. (State) Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Rudiger Breitenecker M.D.				22. DATE SIGNED 8-24-66			
EXAMINER'S NAME (Type) RUDIGER BREITENECKER, M.D.				Address (Street, city, town, or county)			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF AUG. 26		23c. NAME OF CEMETERY OR CREMATORY WOODLAWN		23d. LOCATION (City or Town) (County) (State) EASTON MARYLAND	
24. FUNERAL DIRECTOR Edgar L. Lane ADDRESS CHURCH HILL MD.				25a. REC'D BY REGISTRAR DATE AUG 30 1966		25b. REGISTRAR'S SIGNATURE Charles Judge	

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10869

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10860

1 PLACE OF DEATH a COUNTY ANNE ARUNDEL MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a STATE Maryland b COUNTY ANNE ARUNDEL	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mayo		c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Edgewater	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) ANNE ARUNDEL GENERAL HOSPITAL		d STREET ADDRESS Edgewater P.O.	
3 NAME OF DECEASED (Type or print) First FRANK Middle JOSEPH Last HOWARD		4 DATE OF DEATH Month August Day 28 Year 1966	
5 SEX Male	6 COLOR OR RACE Negro	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 3/2/1918
9 AGE (In years and birthday) 48 yrs		10 IF UNDER 1 YEAR Months 4 Days 8 Hours 48 Min 0	
10a USUAL OCCUPATION (Give kind of work done during most of work life, even if retired) Laborer		10b KIND OF BUSINESS OR INDUSTRY Maryland	
11 BIRTHPLACE (State or foreign country) Maryland		12 CITIZEN OF WHAT COUNTRY U.S.A.	
13 FATHER'S NAME Charles Howard		14 MOTHER'S MAIDEN NAME Bessie Sellman	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) No		16 SOCIAL SECURITY NO. 1974 Belle	
17 INFORMANT Manon Howard		Address 1974 Belle	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))			
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebrocranial injury DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) 124 DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
9 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) Passenger in car which overturned	
20c TIME OF INJURY Month, Day, Year 6:15 p.m. 8-28 1966	20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office, etc.) Street	20f (City or town) (County) (State) Mayo A.A. Md.
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Charles S. Springate M.D.		22. DATE SIGNED August 29, 1966	
EXAMINER'S NAME (Type) Charles S. Springate, M.D.		DEPUTY MEDICAL EXAMINER <input type="checkbox"/> ADDRESS (Street, city, town, or county)	
23a BURIAL, CREMATION, REMOVAL (Specify)	23b DATE THEREOF	23c NAME OF CEMETERY OR CREMATORY	23d LOCATION (City or town) (County) (State)
Burial	9/1/66	Hopes Chapel	Edgewater, Md.
24 FUNERAL DIRECTOR William Reese, Jr. - Anna, Md.		25a REC'D BY REGISTRAR AUG 30 1966	25b REGISTRAR'S SIGNATURE Charles Judge



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

10870

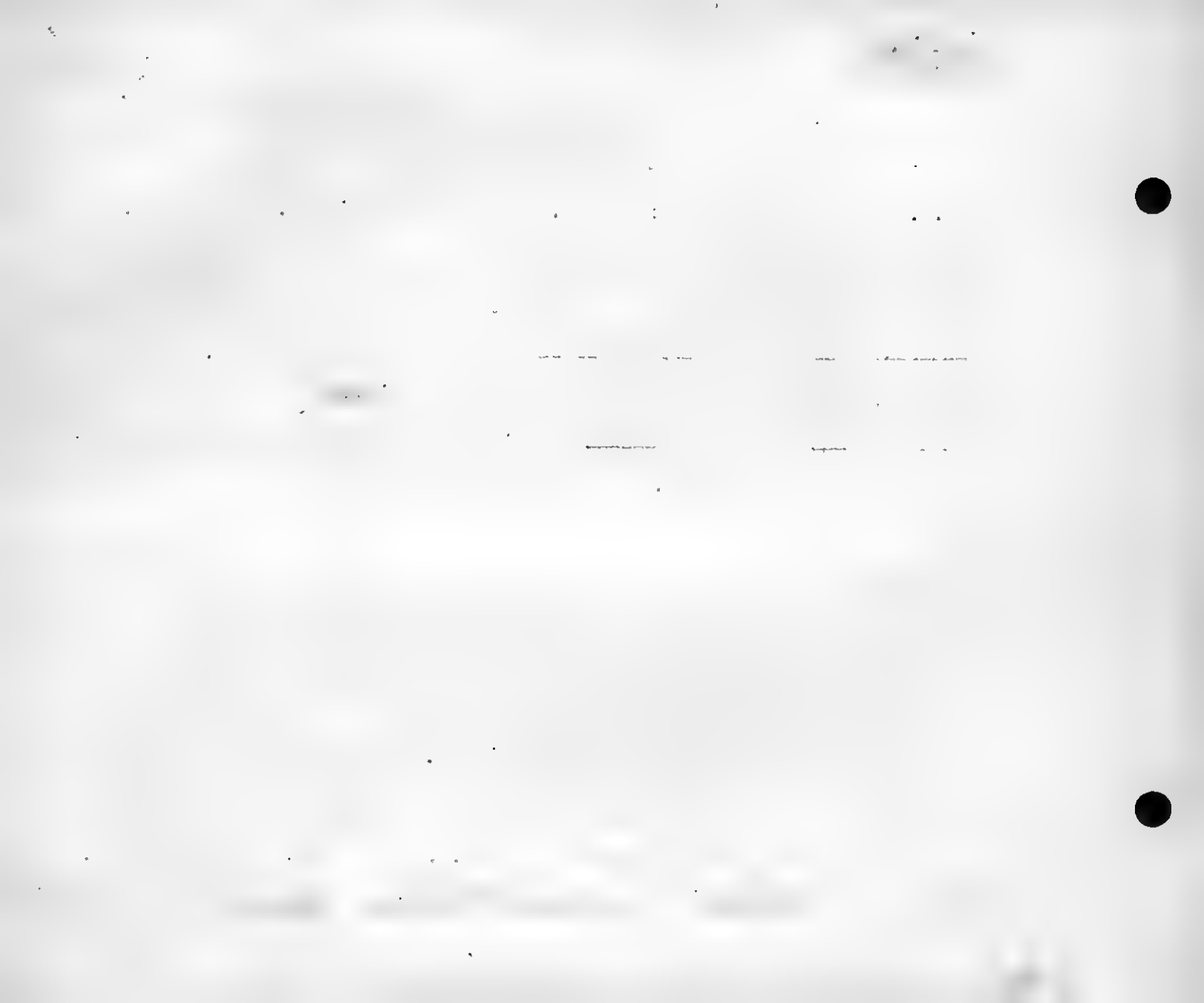
MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

10861

1. PLACE OF DEATH a. COUNTY ANNE ARUNDEL MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE ANNE ARUNDEL b. COUNTY MARYLAND			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) ANNAPOLIS				c. LENGTH OF STAY IN ID 2 DAYS			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) U.S. NAVAL HOSPITAL ANNAPOLIS MD.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First BABY Middle BOY Last HOWELL				4. DATE OF DEATH Month AUGUST Day 24 Year 1966			
5. SEX MALE		6. COLOR OR RACE CAUC		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 22 AUGUST 1966	
9. AGE (In years last birthday) yrs. 1 Months 1 Days 17 Min. 48		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) US NAVAL HOSPITAL ANNA.	
13. FATHER'S NAME JOHN W. HOWELL				14. MOTHER'S MAIDEN NAME MARILEA RAINES			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes give war or dates of service)		17. INFORMANT Address (F) JOHN W. HOWELL 396 MAPLE AVE APT A MD.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PREMATURITY 116X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from AUGUST 22 , 19 66 , to AUGUST 24 , 19 66 , that (I) (we) last saw the deceased alive on 24 AUGUST 19 66 , and that death occurred at 250PM , from the causes and on the date stated above.							
22a. SIGNATURE <i>Richard Ralph Kaiser</i> M.D.						22b. DATE SIGNED 24 AUGUST 1966	
22c. PHYSICIAN'S NAME (Type) RICHARD RALPH KAISER LT MC USNR						22d. ADDRESS U.S. NAVAL HOSPITAL ANNAPOLIS MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATOR		23d. LOCATION (City, town or county) (State)	
BURIAL		8/26/66		U.S. Naval Academy		Annapolis Md.	
24. FUNERAL DIRECTOR <i>John M. Lafferty</i>				25a. REC'D BY REGISTRAR / 25b. REGISTRAR'S SIGNATURE <i>John M. Lafferty</i>			
ADDRESS Annapolis, Md.				DATE AUG 29 1966			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
10871									
CERTIFICATE OF DEATH									
10862									
1. PLACE OF DEATH a. COUNTY <i>Anne Arundel</i> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Anne Arundel</i>				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Portatan Beach</i>			c. LENGTH OF STAY IN 1b <i>20 years</i>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Pasadena, Md.</i>			d. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>none</i>					d. STREET ADDRESS <i>Portatan Beach</i>				
3. NAME OF DECEASED (Type or print)		First <i>JAMES</i>		Middle <i>W.</i>		Last <i>JEWER</i>		4. DATE OF DEATH Month <i>August</i> Day <i>2</i> Year <i>1966</i>	
5. SEX <i>Male</i>		6. COLOR OR RACE <i>White</i>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>April 11, 1911</i>		9. AGE (in years last birthday) <i>55</i> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Stationary Engineer</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>American Brewery</i>		11. BIRTHPLACE (County & State, or foreign country) <i>Baltimore, Md.</i>			12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		
13. FATHER'S NAME <i>John H. Jewer</i>					14. MOTHER'S MAIDEN NAME <i>Frances Jaworski</i>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>					16. SOCIAL SECURITY NO. <i>216-09-3110</i>		17. INFORMANT <i>Mrs. James Jewer</i>		
					Address <i>Pasadena, Md.</i>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Carcinoma of the brain</i> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (c) _____ DUE TO (c) _____								INTERVAL BETWEEN ONSET AND DEATH <i>6 months</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>none</i>								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <i>March 15, 1966</i> , to <i>August 2, 1966</i> , that (I) (we) last saw the deceased alive on <i>August 2, 1966</i> , and that death occurred at <i>8 P.M.</i> from the causes and on the date stated above.									
22a. SIGNATURE <i>R.M. McLaughlin</i>					22b. DATE SIGNED <i>8/2/66</i>				
22c. PHYSICIAN'S NAME (Type) <i>R.M. McLaughlin, M.D.</i>					22d. ADDRESS <i>3108 Mountain Rd. Pasadena, Md.</i>				
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF <i>8-6-66</i>		23c. NAME OF CEMETERY OR CREMATORY GLEN HAVEN CEMETERY			23d. LOCATION (City, town or county) (State) BALTIMORE, MARYLAND		
24. FUNERAL DIRECTOR HOWARD H. HUBBARD					ADDRESS 4107 WILKENS AVENUE 21229		25a. REC'D BY REGISTRAR AUG 4 1966		
					25b. REGISTRAR'S SIGNATURE <i>Charles Juage</i>				

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10873

CERTIFICATE OF DEATH

10863

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY Anne Arundel		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE Maryland		b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. LENGTH OF STAY IN TB 1 day		c. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) Annapolis	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Anne Arundel General Hospital				d. STREET ADDRESS 43 Calvert Street	
3 NAME OF DECEASED (Type or print) Hattie JOHNSON (maiden name -GREEN)		4 DATE OF DEATH Month August Day 27 Year 19 66		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5 SEX Female	6 COLOR OR RACE Negro	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH June 26, 1883	9 AGE (In years last birthday) yrs 83	10 IF UNDER 1 YEAR Months 1 Days 27 Hours 19 Min. 66
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		10b. KIND OF BUSINESS OR INDUSTRY *****		11 BIRTHPLACE (County & State or foreign country) A.A.Co. Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13 FATHER'S NAME Jasper Green		14 MOTHER'S MAIDEN NAME Amelia Harris	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO 214-05-2474-F2		17. INFORMANT James A. Johnson-43 Calvert St. Anna. Md	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebral vascular accident 4221 DUE TO (b) A.C.V.D. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost } DUE TO (c) PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Thrombosis in left femoral vein					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from August 26, 19 66 , to Aug. 27, 19 66 , that (I) (we) last saw the deceased alive on Aug. 19 66 and that death occurred at 11:23 A.M. on Aug. 27, 19 66 , from causes and on the date stated above.					
22a. SIGNATURE Francis W. Allen		22b. DATE SIGNED 8/29/66		22c. PHYSICIAN'S NAME (Type) Francis W. Allen	
22d. ADDRESS 620 Cathedral St					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Aug. 31-66	23c. NAME OF CEMETERY OR CREMATORY Brewer Hill	23d. LOCATION (City or Town) (County) (State) Annapolis, Md.		
24. FUNERAL DIRECTOR C.E. Hicks 111 Annapolis, Md.		25a. REC'D BY REGISTRAR DATE SEP 2 1966	25b. REGISTRAR'S SIGNATURE Charles Judge		

1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any of the information is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 24 hours after death.

V5 A15ME
SM 9, 60

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10864

10873

1. PLACE OF DEATH
a. COUNTY A. A. **MARYLAND**
b. CITY OR TOWN (if outside of corporate limits, write RURAL and give nearest town) Annapolis
c. LENGTH OF STAY IN (b) 12
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) A. A. General

2. USUAL RESIDENCE (Where deceased lived, if (institution); Residence before admission)
a. STATE MD b. COUNTY A. A.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis
d. STREET ADDRESS 55 W. Washington St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒
f. IS RESIDENCE IN A NURSING HOME? YES ☐ NO ☒
g. DATE OF DEATH 8-5- 1966
h. AGE (in years last birthday) 54 yrs. IF UNDER 1 YEAR, IF UNDER 24 HRS.
i. MONTHS 12 j. DAYS 25 k. HOURS 19 l. MIN. 11

3. NAME OF DECEASED (Type or print) James Johnson
4. SEX Male
5. COLOR OR RACE Col.
6. MARRIED ☒ NEVER MARRIED ☐
7. WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH 12-25-1911
9. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer
10. KIND OF BUSINESS OR INDUSTRY MD
11. BIRTHPLACE (State or foreign country) U.S.A.
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Richardson Johnson
14. MOTHER'S MAIDEN NAME Josephine Carpenter
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT Address

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Coronary atherosclerosis
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTE TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year 19
Hour a.m. p.m.
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐ Inspection ☒ Inquiry ☒ and in my opinion death resulted from Natural causes ☐ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED 8-5-66
Address (Street, city, town, or county)

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial
22b. DATE THEREOF 8-10-66
22c. NAME OF CEMETERY OR CREMATORY Brewer Hill
22d. LOCATION (City, town, or county) (State) Annapolis MD

23. FUNERAL DIRECTOR William Reese #1 Address Annapolis MD
24a. REC'D BY REGISTRAR Charles Judge
24b. REGISTRAR'S SIGNATURE Charles Judge
DATE AUG 8 1966

10874

CERTIFICATE OF DEATH

10865

1. PLACE OF DEATH a. COUNTY <u>A. A. CO.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>M.D.</u> b. COUNTY <u>A. A.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. LENGTH OF STAY IN 1b <u>4 DAYS.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Anne Arndel Heim.</u>		d. STREET ADDRESS <u>Severna Parkway</u>	
3. NAME OF DECEASED (Type or print) <u>LAST Johnson, FIRST Josiah, MIDDLE Vaughn</u>		4. DATE OF DEATH <u>8-29-66</u>	
5. SEX <u>M.</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb 26 1904</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Engineer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Const.</u>	
11. BIRTHPLACE (County & State or foreign country) <u>Salisbury Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>J. W. Johnson</u>		14. MOTHER'S MAIDEN NAME <u>Iida F. Johnson</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>MRS. FRANCES B. JOHNSON - SEE R</u>	
17. INFORMANT <u>MRS. FRANCES B. JOHNSON - SEE R</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Renal Sheldoxen</u> DUE TO (b) <u>Toxic disease of the</u> DUE TO (c) <u>nervous system Brown obses?</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>1938</u> , 19__ to <u>1966</u> , 19__, that (I) (we) last saw the deceased alive on <u>8-29-66</u> , and that death occurred at <u>4:30 PM</u> , from causes on and on the date stated above.			
22a. SIGNATURE <u>Robert R. Halun</u> M.D.		22b. DATE SIGNED <u>8-29-66</u>	
22c. PHYSICIAN'S NAME (Type) <u>Robert R. HALUN</u>		22d. ADDRESS <u>P.O. BOX 73 Severna Park</u>	
23a. BURIAL, CREMATION, REINTERMENT (Specify)	23b. DATE THEREOF <u>4/11/1966</u>	23c. NAME OF CEMETERY OR CREMATORY <u>JARSONS CEMETERY</u>	23d. LOCATION (City or Town) (County) (State) <u>SALISBURY MD</u>
24. FUNERAL DIRECTOR <u>HILL FUN. HOME - SALISBURY, MD.</u>		25a. REC'D BY REGISTRAR <u>SEP 2 1966</u>	
		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10875

CERTIFICATE OF DEATH

10866

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. LENGTH OF STAY IN lb D.O.A.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Anne Arundel General Hospital		e. STREET ADDRESS Box-63	
3. NAME OF DECEASED (Type or print) John Harvey JONES		4. DATE OF DEATH Month August Day 1 Year 1966	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 31, 1889
9. AGE (In years last birthday) 77 yrs		10. IF UNDER 1 YEAR Months 1 Days 19 Hours 66	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SUPERVISOR MD STATE HOOSP		10b. KIND OF BUSINESS OR INDUSTRY HENDERSON Maryland	
11. BIRTHPLACE (County & State, or foreign country) U.S.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME JOHN JONES		14. MOTHER'S MAIDEN NAME SUSIE ?	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO	
17. INFORMANT PATTIE ESTELLE JONES #2		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CORONARY THROMBOSIS 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ARTERIOSCLEROTIC HEART DISEASE DUE TO (c) 10 YEARS		INTERVAL BETWEEN ONSET AND DEATH 12 MONTHS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (the deceased) attended the deceased from APR. 11, 1960 , to 1 AUG, 1966 , that (I) (we) saw the deceased alive on 15 July 1966 , and that death occurred at 6:32 AM M. from causes on the date stated above.			
22a. SIGNATURE Edward S. Beck		22b. DATE SIGNED 8-1-66	
22c. PHYSICIAN'S NAME (Type) Edward S. Beck, M.D.		22d. ADDRESS 73 Franklin St., Annapolis, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 8-3-1966	
23c. NAME OF CEMETERY OR CREMATORY HILLCREST MEMORIAL		23d. LOCATION (City or Town) (County) (State) ANNAPOLIS MD	
24. FUNERAL DIRECTOR JOHN M TAYLOR S 3 ANNAPOLIS MD		25a. REC'D BY REGISTRAR DATE AUG 3 1966	
25b. REGISTRAR'S SIGNATURE Charles Judge			

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10876

CERTIFICATE OF DEATH

10867

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Anne Arundel General Hospital		d. STREET ADDRESS 248 Prince George St.	
3. NAME OF DECEASED (Type or print) First Susan Middle Ellen Last JONES		4. DATE OF DEATH Month August Day 26 Year 19 66	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 14, 1874
9. AGE (In years last birthday) 92 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	11. BIRTHPLACE (County & State, or foreign country) Maryland
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY N/A	12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME John Frederick Mace		14. MOTHER'S MAIDEN NAME Harriett Ann Denver	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, not or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO.	
17. INFORMANT Reginal T. Jones		Address #2	
18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Traumatic subdural hematoma 490X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Pneumonia, both left & right lower lobes DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 6 days - 8 days -			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Coronary insufficiency & congestive heart failure			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) Fell out of hospital bed	
20c. TIME OF INJURY Hour 3 Month Aug Day 20 Year 19 66	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) AA Hospital	20f. (City or town) Annapolis (County) AA (State) Md
21. I certify that (I) (at hospital) attended the deceased from July , 19 56 , to Aug. 26 , 19 66 , that (I) (we) saw the deceased alive on Aug. 26 , 19 66 , and that death occurred at 4:25 AM , from causes and on the date stated above.			
22a. SIGNATURE John M. Layla		22b. DATE SIGNED 8/26/66	
22c. PHYSICIAN'S NAME (Type) John M. Layla		22d. ADDRESS Annapolis, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF 8-30-1966	23c. NAME OF CEMETERY OR CREMATORY Cedar Bluff	23d. LOCATION (City or Town) Annapolis (County) Md.
24. FUNERAL DIRECTOR John M. Layla & Sons		25a. REC'D BY REGISTRAR DATE AUG 30 1966	
25b. REGISTRAR'S SIGNATURE Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, (including any event, within 72 hours after death).

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
10877						10868					
1. PLACE OF DEATH						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)					
a. COUNTY			b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			a. STATE			b. COUNTY		
Anne Arundel			New Berlin			Maryland			Baltimore		
c. LENGTH OF STAY IN 1b						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)					
						Baltimore					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)						d. STREET ADDRESS					
Chara Manor Nursing Home						2103 McCulloh St.					
3. NAME OF DECEASED (Type or print)						4. DATE OF DEATH					
Clinton Newton						8 23 1966					
5. SEX		6. COLOR OR RACE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday)		10. IF UNDER 1 YEAR	
male		Negro		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8/3/1909		57 yrs.		Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (County & State, or foreign country)			
Farmer								unknown			
13. FATHER'S NAME						14. MOTHER'S MAIDEN NAME					
Ira Newton						Della					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service)						16. SOCIAL SECURITY NO.		17. INFORMANT			
unknown								Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)											
Coronary Occlusion											
CVA											
Cerebral Atrophy											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
Interval between onset and death											
1 day											
Unknown											
Unknown											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)											
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year											
20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> et work <input type="checkbox"/> et work <input type="checkbox"/>											
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)											
20f. (City or town) (County) (State)											
21. I certify that (I) (this hospital) attended the deceased from 2/26/66 to 8/23/66, that (I) (we) last saw the deceased alive on 8/23/66, and that death occurred at 3 AM, from the causes and on the date stated above.											
22a. SIGNATURE						22b. DATE SIGNED					
Richard H. Hunt						8/23/66					
22c. PHYSICIAN'S NAME (Type)						22d. ADDRESS					
Richard H. Hunt						100 Cherry Lane, New Berlin, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE THEREOF			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City, town or county) (State)		
Burial			8-25-66			Mt. Auburn			Baltimore, Maryland		
24. FUNERAL DIRECTOR'S SIGNATURE						25a. REC'D BY REGISTRAR					
Charles R. Law						25b. REGISTRAR'S SIGNATURE					
802 Madison Ave.						DATE AUG 29 1966					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 should be retained by the hospital or attending physician and completely filled in by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1
MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

10878

CERTIFICATE OF DEATH

10869

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>North Arundel General Hosp.</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> d. STREET ADDRESS <u>2362 Wilkens Ave</u>			
3. NAME OF DECEASED (Type or print) <u>LEO</u>		4. DATE OF DEATH <u>Aug 4, 1966</u>		5. SEX <u>MALE</u>		6. COLOR OR RACE <u>white</u>	
7. MARIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH <u>April 10, 1906</u>		9. AGE (In years, last birthday) <u>60 yrs</u>		10. IF UNDER 1 YEAR <u>4</u> Months <u>4</u> Days <u>19</u> Hours <u>66</u> Min.	
11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Ludwig Kreusinger</u>		14. MOTHER'S MAIDEN NAME <u>?</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>564-01-7223</u>		17. INFORMANT <u>Mary Kreusinger</u>		Address <u>2362 Wilkens Ave</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) DUE TO <u>Coronary occlusion</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, <u>Coronary sclerosis</u> DUE TO (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Interval between onset and death 3 mos</u> <u>3 mos</u>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a.m. <u>19</u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>April, 1965</u> to <u>Aug 4, 1966</u> , that (I) <u>last</u> saw the deceased alive on <u>Aug 3, 1966</u> , and that death occurred at <u>10 AM</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>Frank Pass</u>				22b. DATE SIGNED		22c. PHYSICIAN'S NAME (Type) <u>I. EARL PASS</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>				23b. DATE THEREOF <u>8-8-66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Louisa Park</u>	
23d. LOCATION (City, town or county) <u>Baltimore, Md.</u>				23e. REC'D BY REGISTRAR <u>Charles Judge</u>		23f. REGISTRAR'S SIGNATURE	

CERTIFICATE OF DEATH

10870

10879

1 PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. LENGTH OF STAY IN lb 6hrs.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Anne Arundel General Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL - Arnold	
3 NAME OF DECEASED (Type or print) First Middle Last Rachael Opal LANDRETH		4. DATE OF DEATH Month Day Year August 8 19 66	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 8, 1966
9. AGE (in years last birthday) yrs. 6		10. IF UNDER 1 YEAR Months Days Hours Mins. 6 05	
Do USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Newborn		11. BIRTHPLACE (County & State, or foreign country) Anne Arundel, Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.		13. FATHER'S NAME Delbert Landreth	
14. MOTHER'S MAIDEN NAME Juanita Hall		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No	
16. SOCIAL SECURITY NO. None		17. INFORMANT Delbert Landreth Address Same as 2 - D	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Immaturity - prematurity DUE TO (b) (Birth wt 1 lb. 12 oz.) DUE TO (c) Since birth		INTERVAL BETWEEN ONSET AND DEATH Since birth	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that (I) (the hospital) attended the deceased from 8-8, 1966 to 8-8, 1966 , that (I) (we) lost saw the deceased alive on 8-8, 1966 , and that death occurred at 8:30 PM , from causes on and on the date stated above.	
22a. SIGNATURE Raymond P. Srsic		22b. DATE SIGNED 8-9-66	
22c. PHYSICIAN'S NAME (Type) Raymond P. Srsic, M.D.		22d. ADDRESS 48 Balto-Anna. Blvd., Severna Park, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF August 10, 1966	
23c. NAME OF CEMETERY OR CREMATORY Hillcrest Memorial		23d. LOCATION (City or Town) (County) (State) Annapolis, A.A. Md.	
24. FUNERAL DIRECTOR Charles F. Bell Jr.		25a. REC'D BY REGISTRAR Charles Judge	
25b. REGISTRAR'S SIGNATURE Charles Judge		25c. DATE AUG 11 1966	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. The funeral director should please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



10880

CERTIFICATE OF DEATH

10871

1 PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. LENGTH OF STAY IN 1b 21 days.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Anne Arundel General Hospital		e. STREET ADDRESS Box 336	
3 NAME OF DECEASED (Type or print) John Carlton LEACOCK		4. DATE OF DEATH Month August Day 29 Year 19 66	
5 SEX Male	6 COLOR OR RACE White	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 22, 1905
9. AGE (In years last birthday) 61 yrs.		IF UNDER 1 YEAR Months 29 Days 19 Hours 66 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		10b. KIND OF BUSINESS OR INDUSTRY Construction	
11. BIRTHPLACE (County & State, or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME S. Ralph Leacock		14. MOTHER'S MAIDEN NAME Florence Jackson	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 211-10-9515	
17. INFORMANT Mrs. Florence Leacock		Address Severna Park, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) multiple infarctions both kidneys DUE TO (b) arteriosclerotic Cardiovascular disease DUE TO (c) 2 weeks Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last			INTERVAL BETWEEN ONSET AND DEATH 2 weeks
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes mellitus and pyelonephritis			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from August 8 , 19 66 , to Aug. 29 , 19 66 , that (I) (we) last saw the deceased alive on Aug 29 , 19 66 , and that death occurred at 3:00 A. M, from causes on and on the date stated above			
22a. SIGNATURE Ray M. Smith		22b. DATE SIGNED Aug 29, 1966	
22c. PHYSICIAN'S NAME (Type) RAY M. SMITH M.D.		22d. ADDRESS Severna Park Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF Aug. 29, 1966	23c. NAME OF CEMETERY OR CREMATORY Bloomingsdale Cemetery	23d. LOCATION (City or Town) (County) (State) Bloomingsdale Luzerne, Pa.
24. FUNERAL DIRECTOR Robert J. Kenan		25a. REC'D BY REGISTRAR Severna Park, Md.	
25b. REGISTRAR'S SIGNATURE Charles Judge		DATE SEP 1 1966	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and no later than 72 hours after death.

10881

CERTIFICATE OF DEATH

10872

1 PLACE OF DEATH a. COUNTY Anne Arundel		2. USUAL RESIDENCE (Where deceased lived, if institution- Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie	
c. LENGTH OF STAY IN TB 5 Days		d. STREET ADDRESS 201 Georgia Ave. N/E	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) North Arundel Gen. Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) WILLIAM L. LIEBIG		4 DATE OF DEATH Month August Day 9 Year 1966	
5 SEX Male	6 COLOR OR RACE White	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH Oct. 10, 1896
9 AGE (In years last birthday) 69 yrs.		10 IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Warehouse Mgr. (Ret.)		10b. KIND OF BUSINESS OR INDUSTRY U.S. Steel	
11 BIRTHPLACE (County & State, or foreign country) Richmond Va.		12 CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME (Unknown) Liebig		14. MOTHER'S MAIDEN NAME (unknown)	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes		16. SOCIAL SECURITY NO. 213-03-4588	
17. INFORMANT William F. Liebig (son)		Address Same as # 2	
18 CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Carcinoma Rectum DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) DUE TO (c) DUE TO			INTERVAL BETWEEN ONSET AND DEATH 3 weeks
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) March	20f. (City or town) (County) (State) August 11, 1966
21 I certify that (I) (this hospital) attended the deceased from March , 19 66 , to August , 19 66 , that (I) (we) last saw the deceased alive on August 9 , 19 66 , and that death occurred at 1:45 P.M. from causes and on the date stated above.			
22a. SIGNATURE Charles R. MacDonald		22b. DATE SIGNED 8-10-66	
22c. PHYSICIAN'S NAME (Type) Charles R. MacDonald		22d. ADDRESS 201 Georgia Highway S.W.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Aug. 12, 1966	23c. NAME OF CEMETERY OR CREMATORY Baltimore Nat'l Cemetery	23d. LOCATION (City or Town) (County) (State) Baltimore, Maryland
24. FUNERAL DIRECTOR Richard V. Singleton		25a. REC'D BY REGISTRAR Aug 16 1966	
25b. REGISTRAR'S SIGNATURE Charles Judge			

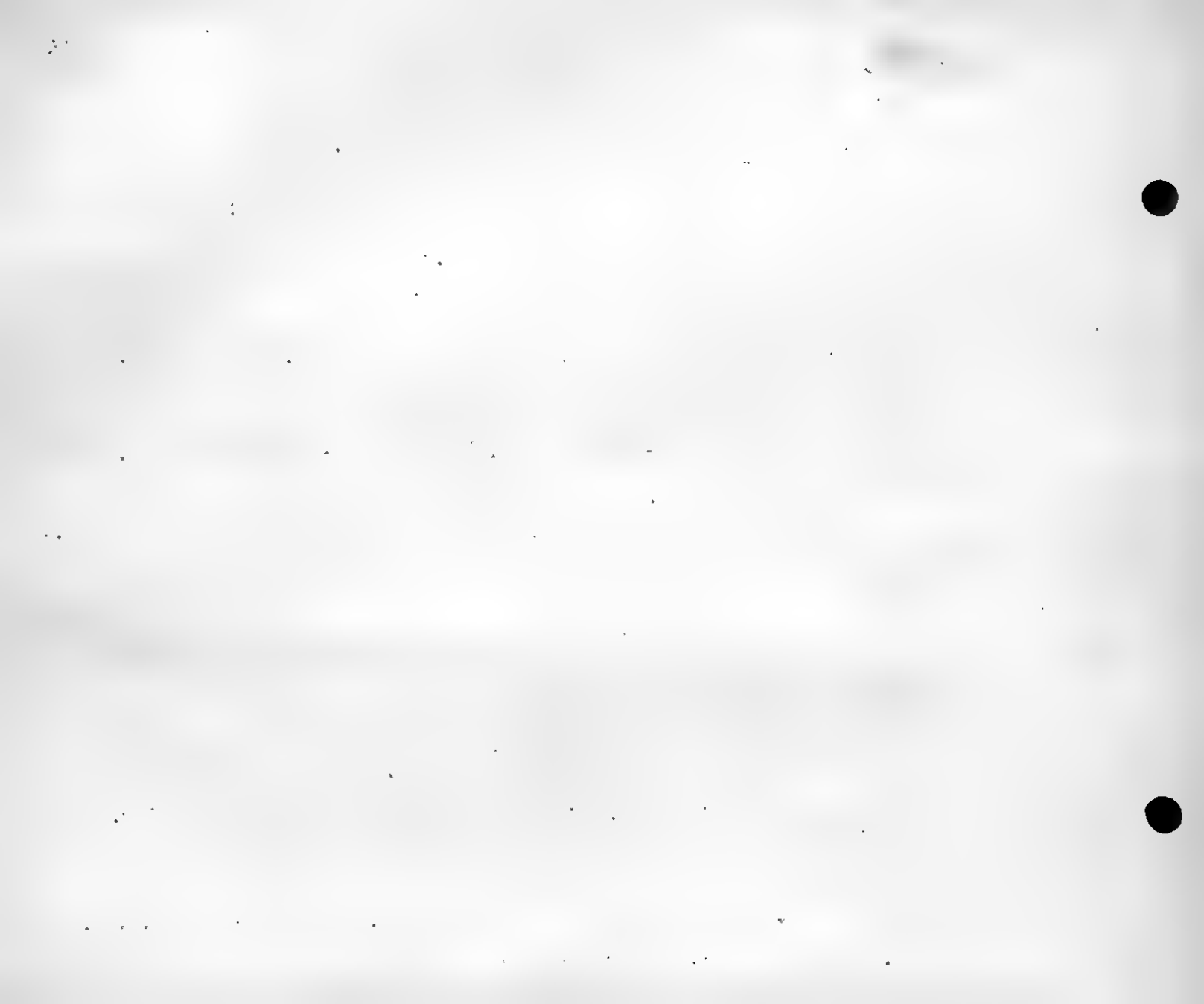
TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove, carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH												
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND												
CERTIFICATE OF DEATH												
1. PLACE OF DEATH a. COUNTY <u>A.A.</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>md.</u> b. COUNTY <u>AA.</u>						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie</u>				c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie</u>						
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>North Arundel Hosp.</u>						d. STREET ADDRESS <u>249 Carroll Rd.</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>CHARLES</u> Middle <u>H.</u> Last <u>List</u>			4. DATE OF DEATH Month <u>8</u> - Day <u>9</u> - Year <u>1966</u>			5. SEX <u>M</u>			6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <u>2-13-02</u>			9. AGE (In years last birthday) <u>64</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Electrician</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Bethlehem Steel</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Baltimore, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>unknown</u>						14. MOTHER'S MAIDEN NAME <u>unknown</u>						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>043-01-7139</u>		17. INFORMANT Address <u>Glen Burnie</u> <u>Mrs. Myrtle List - 249 Carroll Rd.</u>						
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <u>Hypertensive Cardio-Vascular Disease</u> DUE TO (c) <u>11 years</u>										INTERVAL BETWEEN ONSET AND DEATH <u>11 years</u>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Gastric Hemorrhage due to Ulcer</u>												
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>												
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)								
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from <u>8-6</u> , 19 <u>66</u> , to <u>8-9</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>8-9-66</u> , 19 <u>66</u> , and that death occurred at <u>6:30</u> PM, from the causes and on the date stated above.												
22a. SIGNATURE <u>Charles R. Meskunas MD</u>						22b. DATE SIGNED <u>8-9-66</u>			22c. PHYSICIAN'S NAME (Type) <u>204 CRAIN HWY. SO. GLEN BURNIE MD</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				23b. DATE THEREOF <u>Aug. 12, 1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Glen Haven Memorial Pk.</u>		23d. LOCATION (City, town or county) (State) <u>Ritchie Hwy. AA Co. Md.</u>				
24. FUNERAL DIRECTOR <u>George J. Gonce - 4001 Ritchie Hwy., Baltimore</u>						25a. REC'D BY REGISTRAR <u>AUG 12 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>				



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10282

CERTIFICATE OF DEATH

10874

1 PLACE OF DEATH a. COUNTY ANN ARUNDEK b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) FT. G. G. MEADE, MD. c. LENGTH OF STAY IN TB ODENTON d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) KIMBROUGH ARMY HOSPITAL		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE md. b. COUNTY AA c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ODENTON d. STREET ADDRESS 515 RITA DR. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) BETTY		4 DATE OF DEATH Month AUGUST Day 11 Year 1966	
5 SEX FEMALE	6. COLOR OR RACE CAUC.	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12 OCT. 1891
9. AGE (In years last birthday) 74 yrs		10. IF UNDER 1 YEAR Months 7 Days 11 Hours 24 Mins	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WIFE		10b. KIND OF BUSINESS OR INDUSTRY NONE	
11 BIRTHPLACE (County & State, or foreign country) NEW YORK, NY.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME GUSTANE MARTEL		14. MOTHER'S MAIDEN NAME ROSE	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO. N/N	
17. INFORMANT MRS. VIVIAN MCGHAN		Address 515 Rita Dr. Odenton	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CARDIAC STANDSTILL DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) CARCINOMA OF PANCREAS POST- RESECTION DUE TO (c) POST-OPERATIVE INTRA ABDOMINAL ABSCESS		INTERVAL BETWEEN ONSET AND DEATH OPERATION 20 JUNE 66 5 AUG 66	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 22 MAY , 1966, to 11 AUG , 1966, that (I) (we) last saw the deceased alive on 11 AUG , 1966, and that death occurred at 6 A.M. , from causes and on the date stated above.			
22a. SIGNATURE <i>Raymond E. Ponce</i>		22b. DATE SIGNED 11 AUG 66	
22c. PHYSICIAN'S NAME (Type) Raymond E. Ponce		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Aug. 13, 1966	23c. NAME OF CEMETERY OR CREMATORY St. Marys Cemetery	23d. LOCATION (City or Town) (County) (State) Laurel, Maryland
24. FUNERAL DIRECTOR <i>De Witt Donaldson</i>		25a. REC'D BY REGISTRAR DATE AUG 22 1966	
25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the general director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (pages 1 and 2) should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
20M 1/65

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY		b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE		b. COUNTY	
ANNIE ARUNDEL		ANNAPOLIS		20YRS. 10MOS		MARYLAND		ANNA ARUNDEL	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)						e. STREET ADDRESS		f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
U.S. NAVAL HOSPITAL						1102 VAN BUREN ST.			
3. NAME OF DECEASED (Type or print)		First		Middle		Last		4. DATE OF DEATH Month Day Year	
EDWARD LEE MCCARTER								AUG. 20 1966	
5. SEX		6. COLOR OR RACE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday) Months Days Hours Min.	
MALE		CAUCASIAN				DEC. 13 1896		69 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
GUARD USN EXPERIMENTAL STATION						MAYO, ANNE ARUNDEL MARYLAND		AMERICAN	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME					
DURWOOD MCCARTER				MARY LEE WHEELER					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO.		17. INFORMANT		Address	
YES				APRIL 1917-1937 212 36 832		MRS. RUTH S. MCCARTER		1102 VAN BUREN ANNIAPOLIS, MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiac arrest</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) <i>Prostatic carcinoma, metastatic</i> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)									
INTERVAL BETWEEN ONSET AND DEATH 11 AUG. 66 20 AUG. 66									
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
MEDICAL CERTIFICATION 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)									
21. I certify that (I) (this hospital) attended the deceased from <i>AUG. 11</i> , 1966, to <i>AUG. 20</i> , 1966, that (I) (we) last saw the deceased alive on <i>AUG. 20</i> , 1966, and that death occurred at <i>M</i> , from the causes and on the date stated above.									
22a. SIGNATURE <i>C. L. Gaudry</i>						22b. DATE SIGNED <i>20 Aug 66</i>			
22c. PHYSICIAN'S NAME (Type) CHARLES L. GAUDRY, JR.						22d. ADDRESS US NAVAL HOSPITAL ANNAPOLIS, MD.			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE OF REMOVAL		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town or county) (State)			
BURIAL		8-23-66		GLEN HAVEN		BRIGHTON, GLEN BURNIE, MD			
24. FUNERAL DIRECTOR <i>John M. Taylor</i>						25a. REC'D BY REGISTRAR <i>Charles Judge</i>			
ANNAPOLIS, MD.						DATE AUG 23 1966			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages one and two should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
Item 9 Film 1379 8/14/66 mh

10885

CERTIFICATE OF DEATH

10876

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>✓</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pasadena</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Pinehurst Road</u>		d. STREET ADDRESS <u>574 E. 36th Street</u>	
3. NAME OF DECEASED (Type or print) First <u>James</u> Middle <u>Joseph</u> Last <u>McDonnell Sr.</u>		4. DATE OF DEATH Month <u>August</u> Day <u>10</u> Year <u>1966</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 29, 1902</u> 9. AGE (in years last birthday) <u>64</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clothing Mfg.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Clothing</u>	
11. BIRTHPLACE (County & State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John P. McDonnell</u>		14. MOTHER'S MAIDEN NAME <u>Bridget Feeney</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>unknown</u>	
17. INFORMANT <u>Rosalie M. McDonnell</u>		Address <u>574 E. 36th St Balt</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of right lung -</u> DUE TO (b) <u>163X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } DUE TO (c) <u>cardio-vascular disease</u>		INTERVAL BETWEEN ONSET AND DEATH <u>Feb. 24, 66</u> <u>Mar. 10, 66</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>none</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <u>NONE</u>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Feb. 24, 1966</u> to <u>Aug. 16, 1966</u> ; that (I) (we) last saw the deceased alive on <u>Aug. 16, 1966</u> and that death occurred at <u>_____</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>Frank N. Ogden</u>		22b. DATE SIGNED <u>Aug. 12, 1966</u>	
22c. PHYSICIAN'S NAME (Type) <u>FRANK N. OGDEN, M.D.</u>		22d. ADDRESS <u>2701 N. Calver St.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>8/13/66</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>New Cathedral Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Baltimore Md.</u>	
24. FUNERAL DIRECTOR <u>John A. Moran, Inc.</u>		25a. REC'D BY REGISTRAR <u>AUG 15 1966</u>	
ADDRESS <u>3000 E. Balto. St. Balto.</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

10886

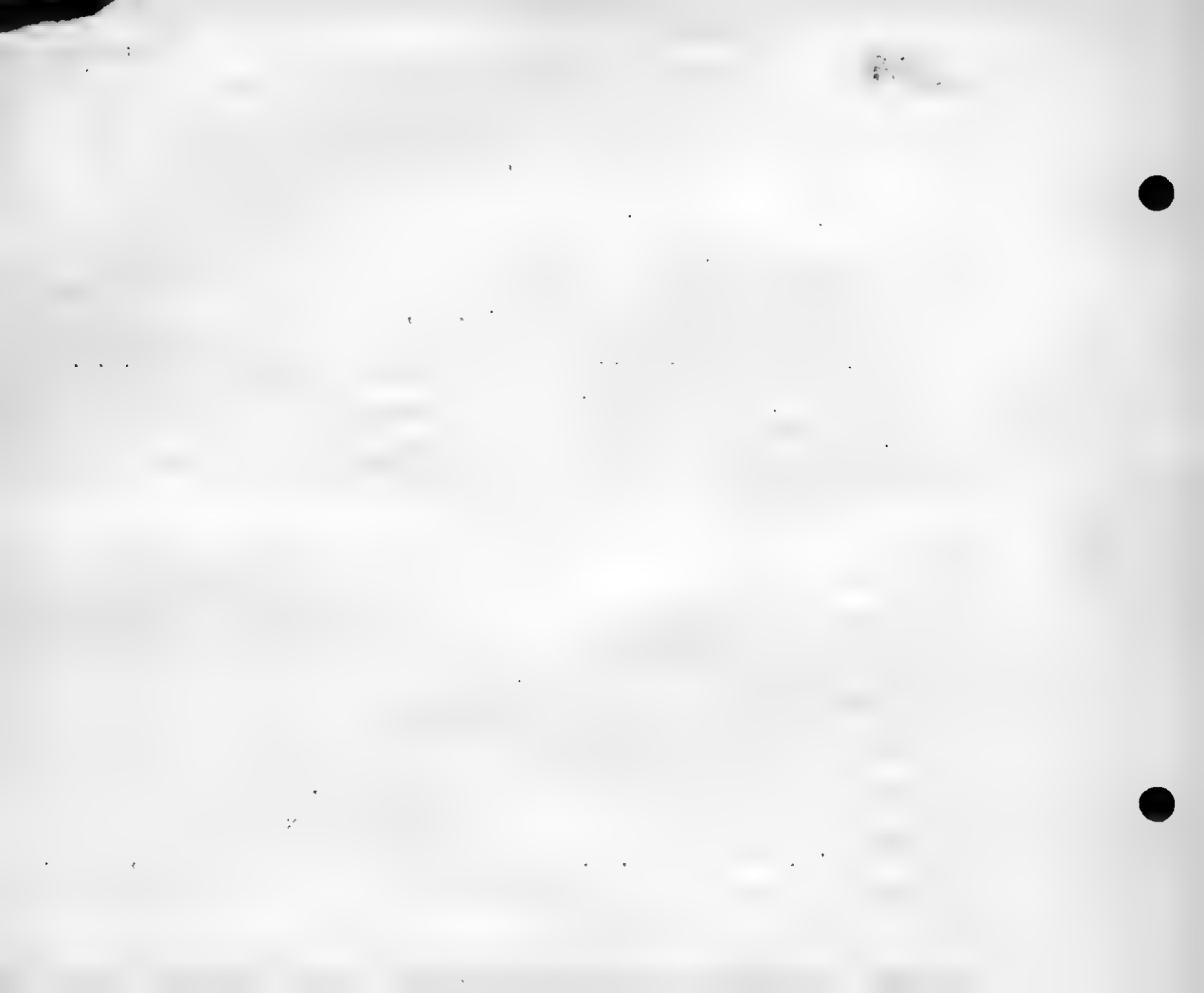
CERTIFICATE OF DEATH

10872

1 PLACE OF DEATH a. COUNTY Anne Arundel		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville		c. LENGTH OF STAY IN 1b 2mo. 23 days		2 USUAL RESIDENCE (Where deceased lived, if instnat before admission) a. STATE Maryland		b. COUNTY Baltimore City ✓	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Crownsville State Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				d. STREET ADDRESS 1213 Light Street	
3 NAME OF DECEASED (Type or print) 3-#32049 Lucille		First		Middle		Last McLean		4. DATE OF DEATH Month 8 Day 3 Year 19 66	
5 SEX Female		6 COLOR OR RACE Negro		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8 DATE OF BIRTH Aug. 20, 1910		9. AGE (In years last birthday) 55 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unknown		10b. KIND OF BUSINESS OR INDUSTRY Domestic		11 BIRTHPLACE (County & State, or foreign country) Unknown Virginia		12 CITIZEN OF WHAT COUNTRY? U.S.A.			
13 FATHER'S NAME Unknown Jamie Taylor				14. MOTHER'S MAIDEN NAME Unknown Emma?					
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Unknown		16. SOCIAL SECURITY NO Unknown		17. INFORMANT Hospital Records				Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia 493X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____								INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic Brain Syndrome; Epilepsy								19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) --		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) -----							
20c. TIME OF INJURY Month, Day, Year Hour a.m. ----- p.m. ----- 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office, bldg., etc.) -----		20f. (City or town) (County) (State) -----			
21. I certify that (I) (this hospital) attended the deceased from 5/10 , 19 66 , to 8/3 , 19 66 , that (I) (we) last saw the deceased alive on 8/3 , 19 66 , and that death occurred at 4:20 P.M. from causes and on the date stated above									
22a. SIGNATURE L. Benedict				M.D. ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS <input type="checkbox"/>				22b. DATE SIGNED 8/3/66	
22c. PHYSICIAN'S NAME (Type) L. Benedict, M. D.				22d. ADDRESS Crownsville State Hospital, Maryland					
23a. BURIAL, CREMATION, REMOVAL (Specify) 8/8/66		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery		23d. LOCATION (City or Town) (County) (State) A. A. A. Md			
24. FUNERAL DIRECTOR Robert E. Williams				25a. RECD BY REGISTRAR DATE AUG 5 1966		25b. REGISTRAR'S SIGNATURE Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



10887

CERTIFICATE OF DEATH

10878

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Baltimore City	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Crownsville State Hospital		d. STREET ADDRESS 26 S. Exeter St.	
3. NAME OF DECEASED (Type or print) James W. McQuaige		4. DATE OF DEATH Month 8 Day 30 Year 1966	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH September 16, 1887
9. AGE (In years last birthday) 78 yrs		10. IF UNDER 1 YEAR Months 0 Days 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unknown		10b. KIND OF BUSINESS OR INDUSTRY Unknown	
11. BIRTHPLACE (County & State, or foreign country) Unknown		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Unknown		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT Hospital Records		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute Coronary Insufficiency DUE TO Coronary arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost } DUE TO (b) _____ (c) _____			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic Brain Syndrome Secondary to Cerebral Arteriosclerosis			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) ---		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) -----	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19	20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) -----	20f. (City or town) (County) (State) -----
21. I certify that (I) (this hospital) attended the deceased from 9/14 , 19 64 , to 8/30 , 19 66 , that (I) (we) last saw the deceased alive on 8/30 , 19 66 , and that death occurred at 1:50 P.M. , from causes and on the date stated above.			
22a. SIGNATURE <i>L. Benedict</i>		22b. DATE SIGNED 8/30/66	
22c. PHYSICIAN'S NAME (Type) L. Benedict, M. D.		22d. ADDRESS Crownsville State Hospital, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 9/2/66	23c. NAME OF CEMETERY OR CREMATORY UNIV. OF MED. SCHOOL	23d. LOCATION (City or Town) (County) (State) BALTIMORE, Md.
24. FUNERAL DIRECTOR W. Reese		25a. REC'D BY REGISTRAR SEP 6 1966	
25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

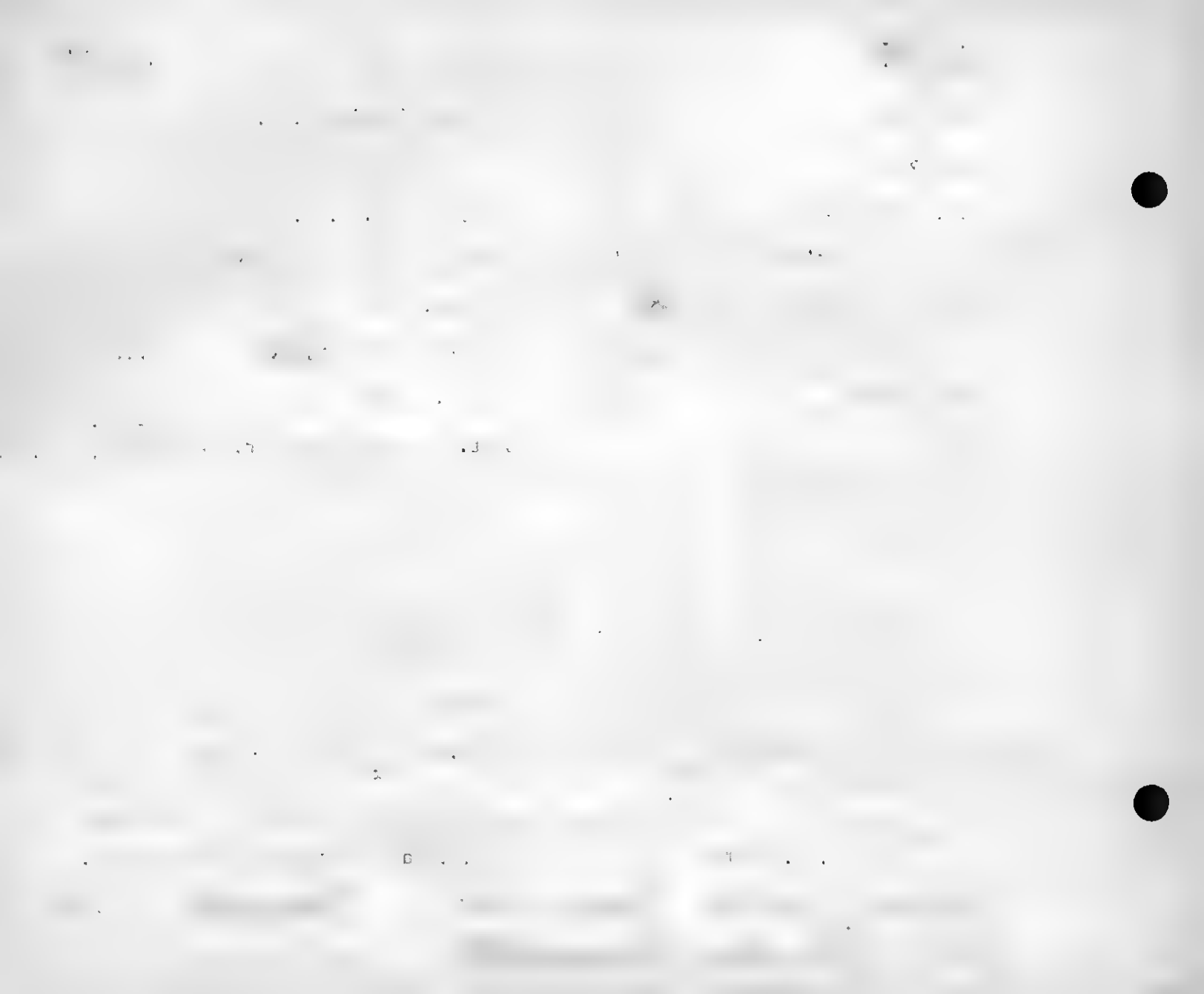
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove person's papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

<div> <div>1</div> <div> <div>10888</div> <div>10879</div> </div> </div> <div> <div>MARYLAND STATE DEPARTMENT OF HEALTH</div> <div>DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</div> <div>CERTIFICATE OF DEATH</div> </div>											
1. PLACE OF DEATH a. COUNTY Anne Arundel						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Washington, D. C. b. COUNTY					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Annapolis				c. LENGTH OF STAY IN 1b MARYLAND		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)				d. STREET ADDRESS 1731 N St. N. W.	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) U.S. Naval Hospital						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) HELEN (N) MEADE						4. DATE OF DEATH August 13 1966		5. SEX Female		6. COLOR OR RACE Cauc	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH 10 Dec. 1879		9. AGE (in years last birthday) 86 yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NA		10b. KIND OF BUSINESS OR INDUSTRY NA		11. BIRTHPLACE (County & State, or foreign country) Pittsylvania Co. Va.	
12. CITIZEN OF WHAT COUNTRY? U.S.						13. FATHER'S NAME John James					
14. MOTHER'S MAIDEN NAME A. Jones						15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No					
16. SOCIAL SECURITY NO.						17. INFORMANT Capt. Randolph Meade Jr. Providence, Anna. Md.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory Arrest DUE TO (b) Pneumonia, 61k fever 1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) 3 days PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) ASHD & Congestive Heart Failure											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)											
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)				20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)				21. I certify that (I) (this person) attended the deceased from 11 August , 19 66 , to 13 August , 19 66 , that (I) (was) last saw the deceased alive on 13 August , 19 66 , and that death occurred at 6:30 AM , from the causes and on the date stated above.			
22a. SIGNATURE J. P. McGrory						22b. DATE SIGNED 13 August 1966		22c. PHYSICIAN'S NAME (Type) T. P. McGrory		22d. ADDRESS U.S. Naval Hospital Annapolis, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL				23b. DATE THEREOF 8-15-66		23c. NAME OF CEMETERY OR CREMATORY GREEN HILL		23d. LOCATION (City, town or county) (State) DANVILLE Va.			
24. FUNERAL DIRECTOR John M. Taylor & Sons Annapolis, Md.						25a. REC'D BY REGISTRAR AUG 15 1966					
25b. REGISTRAR'S SIGNATURE Charles Judge											



1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
Items #11 & 12 Film #U380 8/23/66 pc											
10889 10880											
1. PLACE OF DEATH a. COUNTY <u>ANNE ARUNDEL</u>						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE <u>MARYLAND</u> b. COUNTY <u></u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie</u>						c. LENGTH OF STAY IN 1b <u>18 mo.</u>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Plaza Manor Nursing Home</u>						d. STREET ADDRESS <u>UNKNOWN</u>					
3. NAME OF DECEASED (Type or print) First <u>James</u> Middle <u>Morgan</u> Last <u></u>						4. DATE OF DEATH Month <u>Aug.</u> Day <u>17</u> Year <u>1966</u>					
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>3/15/81</u>		9. AGE (In years last birthday) <u>85</u> yrs.		IF UNDER 1 YEAR Months <u></u> Days <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>UNKNOWN</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>?</u>		11. BIRTHPLACE (County & State, or foreign country) <u>UNKNOWN</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>James Morgan</u>						14. MOTHER'S MAIDEN NAME <u>MARY ?</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>?</u>						16. SOCIAL SECURITY NO. <u>216-32-9991</u>					
17. INFORMANT <u>Plaza Manor Nursing Home- Glen Burnie, Md.</u>						Address <u></u>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u>											
Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) <u>Myocardial Infarction</u> (c) <u>Chronic Debrid Syndrome</u>											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e) <u>Interval Between Onset and Death 1 day</u>											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)											
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u></u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>2/2/65</u> , 19 <u>65</u> to <u>Aug. 17</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>Aug. 17</u> , 19 <u>66</u> , and that death occurred at <u>8 PM</u> , from the causes and on the date stated above.											
22a. SIGNATURE <u>Richard H. Hunt</u>						22b. DATE SIGNED					
22c. PHYSICIAN'S NAME (Type) <u>Richard H. Hunt</u>						22d. ADDRESS <u>100 Cherry Lane - Glen Burnie, Md.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				23b. DATE THEREOF <u>Aug. 20, 1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Glen Haven Memorial Park Ritchie Hwy., A.A.Co., Md.</u>				23d. LOCATION (City, town or county) (State)	
24. FUNERAL DIRECTOR'S SIGNATURE <u>George J. Gonce-4001 Ritchie Hwy., Baltimore</u>						25a. REC'D BY REGISTRAR DATE <u>AUG 22 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

10890

CERTIFICATE OF DEATH

10881

1. PLACE OF DEATH a. COUNTY ANNE ARUNDEL MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MARYLAND b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT GEORGE G. MEADE		c. LENGTH OF STAY IN lb 27 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) KIMBROUGH ARMY HOSPITAL		e. STREET ADDRESS 113 F ROCK GLEN ROAD	
3. NAME OF DECEASED (Type or print) First DAVID Middle J. Last MORRIS SH		4. DATE OF DEATH Month AUGUST Day 22 Year 19 66	
5. SEX MALE	6. COLOR OR RACE CAU	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 30 June 1896
9. AGE (In years last birthday) YRS 70		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Serviceman Retired		10b. KIND OF BUSINESS OR INDUSTRY U.S. Army	
11. BIRTHPLACE (County & State or foreign country) Marietta, Georgia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME LeRoy Morris		14. MOTHER'S MAIDEN NAME Laurel Wellborn	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes 9/2/14-9/7/1947		16. SOCIAL SECURITY NO. 216-32-9123	
17. INFORMANT (son) David J. Morris, Jr.		Address 7011 Crest Haven Dr Glen Burnie, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIAC ARREST DUE TO ARTERIOSCLEROTIC HEART DISEASE WITH (b) ATRIAL FIBRILLATION DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 10 MIN. UNDET.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Fracture left hip		19. WAS A JTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)	20f. (City or town) (County) (State)
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 25 July , 19 66 to 22 Aug , 1966, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 22 Aug , 19 66 , and that death occurred at 2:25 M. from causes and on the date stated above.			
22a. SIGNATURE <i>Alan Wanderer</i>		22b. DATE SIGNED 22 Aug 1966	
22c. PHYSICIAN'S NAME (Type) ALAN WANDERER, Capt, MC		22d. ADDRESS KIMBROUGH ARMY HOSP, FT GEO G MEADE, MD	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF 8/25/66	23c. NAME OF CEMETERY OR CREMATORY U.S. NATIONAL CEMETERY	23d. LOCATION (City or Town) (County) (State) BALTIMORE, MD.
24. FUNERAL DIRECTOR R.V. SINGLETON		25a. REC'D BY REGISTRAR DATE AUG 25 1966	
ADDRESS GLEN BURNIE, MD.		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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FRONTIER TAP

X

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if any delay is necessary, please execute the certificate, writing the word 'pending' in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

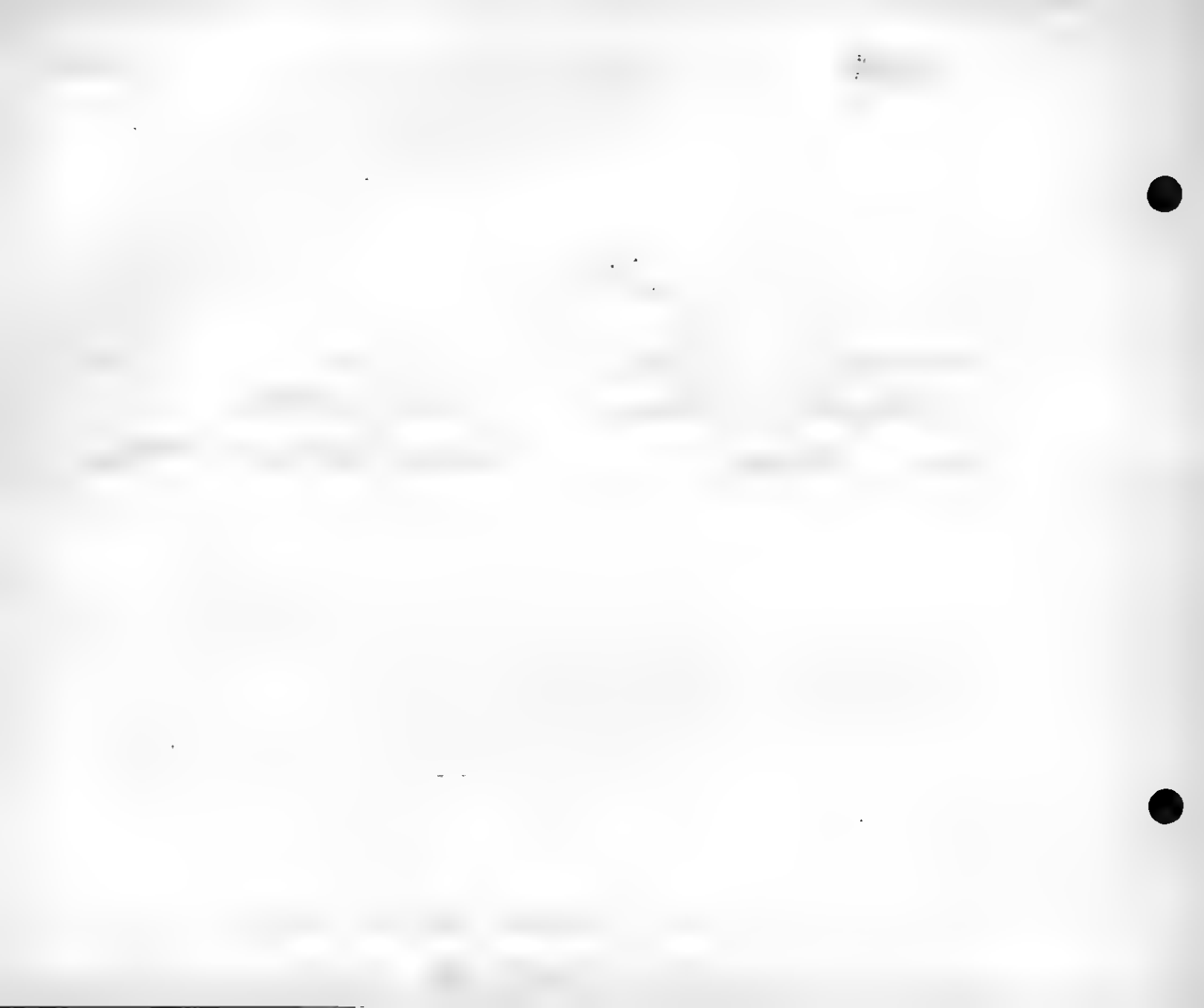
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10891

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10882

1 PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) ANNE ARUNDEL GENERAL HOSPITAL				d. STREET ADDRESS 1 Riverview Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) WILMA JEAN MORROW		First Middle Last		4 DATE OF DEATH August 23 1966		Month Day Year	
5 SEX Female	6 COLOR OR RACE White	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 3-27-36		9 AGE (In years last birthday) yrs 30	10 UNDER 1 YEAR Months Days	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired) Waitress		10b. KIND OF BUSINESS OR INDUSTRY Restaurant		11 BIRTHPLACE (State or foreign country) Florida		12 CITIZEN OF WHAT COUNTRY? USA	
13 FATHER'S NAME Chester H. Yeomans				14 MOTHER'S M maiden NAME Ruth Sutton			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes Korea		16. SOCIAL SECURITY NO.		17 INFORMANT Clark D. Morrow Address #2			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple injuries DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) _____ DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) Driver in auto-auto collision					
20c. TIME OF INJURY Month, Day Year 12:00 pm 8 23 19 66		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) Street		20f. (City or town) (County) (State) Route 50 A. A., Md.	
21 I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Werner U. Spitz, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> Address (Street, city, town, or county)				22. DATE SIGNED 8-23-66	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 8-26-1966		23c. NAME OF CEMETERY OR CREMATORY Arlington National		23d. LOCATION (City or Town) (County) (State) Arlington Va.	
24. FUNERAL DIRECTOR John M. Taylor & Sons Annapolis, Md.				25a. REC'D BY REGISTRAR Charles Judge		25b. REGISTRAR'S SIGNATURE Charles Judge	



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10892

CERTIFICATE OF DEATH

10883

1 PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Maryland b. COUNTY Charles	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville		c. LENGTH OF STAY IN 1b 11 mos. 20 das.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Crownsville State Hospital		e. STREET ADDRESS None	
3. NAME OF DECEASED (Type or print) #30316 Lillian Jarrett Murphy		4. DATE OF DEATH Month 8 Day 31 Year 1966	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/18/1892
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unknown House Wife		10b. KIND OF BUSINESS OR INDUSTRY - At Home	11. BIRTHPLACE (County & State, or foreign country) Maryland
13. FATHER'S NAME Unknown Jack Rice		14. MOTHER'S MAIDEN NAME Unknown Docele Faren	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 217-35-7865 INFORMANT Unknown Hospital Records	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrest 6371 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) severe vaginal hemorrhage DUE TO (c) previous C.N.A.		INTERVAL BETWEEN ONSET AND DEATH 1 week.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) -----	
20c. TIME OF INJURY Month, Day, Year Hour 11 p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 9/11/1965 , to 8/31/1966 , that (I) (we) last saw the deceased alive on 8/31/1966 , and that death occurred at 5:40 M., from causes on and on the date stated above			
22a. SIGNATURE L. Benedict, M.D.		22b. DATE SIGNED 8/31/66	
22c. PHYSICIAN'S NAME (Type) L. Benedict, M.D.		22d. ADDRESS Crownsville, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF 9-3-66	23c. NAME OF CEMETERY OR CREMATORY Sacred Heart Cemetery	23d. LOCATION (City or town) (County) (State) La Plata, Maryland
24. FUNERAL DIRECTOR AREHART FUNERAL HOME INC.		25a. REC'D BY REGISTRAR LA PLATA, MD	25b. REGISTRAR'S SIGNATURE Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the bur-at-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

10293

CERTIFICATE OF DEATH

10884

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institut an Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Anne Arundel General Hospital		d. STREET ADDRESS 785 Sonne Drive	
3. NAME OF DECEASED (Type or print) First Elsie Middle Bernardina Last NELSON		4. DATE OF DEATH Month August Day 17 Year 1966	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 11, 1900
9. AGE (In years last birthday) 65 yrs		10. IF UNDER 1 YEAR <input type="checkbox"/> IF UNDER 24 HRS <input type="checkbox"/> Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Sweden	
11. BIRTHPLACE (County & State or foreign country) Sweden		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME -----Oquist		14. MOTHER'S MAIDEN NAME Stina---	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT Otto J. Nelson same as #2		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia 6000 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Chronic pyelonephritis DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 1 yr	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <input type="checkbox"/> p.m. <input type="checkbox"/> 19 <input type="checkbox"/>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (the hospital) attended the deceased from 1965 to Aug. 17, 1966 , that (I) (we) last saw the deceased alive on Aug. 17 19 66 , and that death occurred at M , from causes and on the date stated above.			
22a. SIGNATURE Richard N. Peeler		22b. DATE SIGNED 9:30 PM	
22c. PHYSICIAN'S NAME (Type) Richard N. Peeler, M.D.		22d. ADDRESS 121 Cathedral St., Annapolis, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) burial		23b. DATE THEREOF 8/20/66	
23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery		23d. LOCATION (City or town) (County) (State) Prince Georges County, Md.	
24. FUNERAL DIRECTOR The S.H. Hines Company		25. REGISTRAR'S SIGNATURE Charles Judge	

10894

CERTIFICATE OF DEATH

10885

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a COUNTY ANNE ARUNDEL MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY ANNE ARUNDEL	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FT GEO G MEADE, MD.		c. LENGTH OF STAY in 1b 26 Days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) KIMBROUGH ARMY HOSPITAL		d. STREET ADDRESS 4527 Butler St	
3 NAME OF DECEASED (Type or print) WILLIAM C. NEWMAN		4 DATE OF DEATH Month AUG Day 29 Year 19 66	
5. SEX MALE	6 COLOR OR RACE WHITE	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 12 July 1914
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SOLDIER		10b. KIND OF BUSINESS OR INDUSTRY U.S. ARMY	9. AGE (n years last birthday) 52 yrs
11. BIRTHPLACE (County & State, or foreign country) TULSA, ALABAMA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME WILLIAM NEWMAN		14. MOTHER'S MAIDEN NAME BRYANT CARRIE	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) AUG 1940		16. SOCIAL SECURITY NO 224523927	
17. INFORMANT THELMA L. NEWMAN/WIFE/		Address (Same as item # 2)	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) LAENNEC'S CIRRHOSIS DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			INTERVAL BETWEEN ONSET AND DEATH 3 1/2
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) NONE			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 3 Aug , 19 66 , to 29 Aug , 19 66 that (I) (we) last saw the deceased alive on 29 Aug , 19 66 , and that death occurred at 0655AM , from causes and on the date stated above.			
22a. SIGNATURE <i>George W. Lutz</i>		22b. DATE SIGNED 29 Aug 66	
22c. PHYSICIAN'S NAME (Type) GEORGE W. LUTZ, CAPT, MSC		22d. ADDRESS KIMBROUGH ARMY HOSPITAL, FT GEO G. MEADE MD	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF Sept. 1, 1966	23c. NAME OF CEMETERY OR CREMATORY ARLINGTON NATIONAL CEM.	23d. LOCATION (City or Town) (County) (State) ARLINGTON, VIRGINIA
24. FUNERAL DIRECTOR HAROLD S. Wade, 550 Wash. Blvd., Laurel, Maryland		25a. REC'D BY REGISTRAR SEP 7 1966	
		25b. REGISTRAR'S SIGNATURE <i>J. Charles Judge</i>	

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10895

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10886

1 PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2 USUAL RESIDENCE (Where deceased lived f. institution Residence before admn'ssion) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Anne Arundel General Hospital		d. STREET ADDRESS 2822 Denham Circle	
3 NAME OF DECEASED (Type or print) First* LEVI Middle STANLEY Last NICHOLSON		4 DATE OF DEATH Month August Day 26 Year 1966	
5 SEX Male	6 COLOR OR RACE Negro	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH Nov. 6/1946
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Aid Recreation Center Balto. Md.		10b. KIND OF BUSINESS OR INDUSTRY	9 AGE (in years last birthday) yrs 19
11 BIRTHPLACE (State or foreign country) Balto. Md.		12 CITIZEN OF WHAT COUNTRY?	
13 FATHER'S NAME Charles Nicholson		14 MOTHER'S MAIDEN NAME Alease Johnson	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16 SOCIAL SECURITY NO	
17 INFORMANT Alease J. Nicholson		Address 2822 Denham Cir.	
18 CAUSE OF DEATH (Enter on any one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Asphyxia 1270 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Drowning. DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PR. MARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) Drowned while attempting to swim.	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 8/26 1966	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Beach	20f. (City or town) (County) (State) Carr's Beach A.A. Md.
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Charles S. Petty, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASS STANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> Address (Street, city, town, or county)	
22. DATE SIGNED 8/27/66			
23a. BURIAL CREMATION, REMOVAL (Specify)	23b. DATE THEREOF 8/30/1966	23c. NAME OF CEMETERY OR CREMATORY St. Luke's Cemetery	23d. LOCATION (City or town) (County) (State) Balto. Md.
24. FUNERAL DIRECTOR William Turner Home	25a. REC'D BY REGISTRAR 3/19/1966	25b. REGISTRAR'S SIGNATURE Charles Judge	DATE AUG 29 1966

10115107

10897

CERTIFICATE OF DEATH

10888

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Anne Arundel b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis c. LENGTH OF STAY IN 1b Annopolis d. NAME OF HOSPITAL OR INST TUTION (If not in hospital, give street address) Anne Arundel General Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Arnold d. STREET ADDRESS Roe Lane, Hollyanna Acres e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Edward Oliver NORFOLK		4. DATE OF DEATH Month Day Year August 15 19 66	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1884 April 8, 1966*
9. AGE (n years last birthday) yrs 82		10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Drawbridge tender		10b. KIND OF BUSINESS OR INDUSTRY State gov't.	11. BIRTHPLACE (County & State, or foreign country) Calvert Co., Md.
12. CITIZEN OF WHAT COUNTRY? U. S.		13. FATHER'S NAME Samuel Norfolk	
14. MOTHER'S MAIDEN NAME Hattie Trotter		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no	
16. SOCIAL SECURITY NO. 214-05-1437		17. INFORMANT Mrs. Harry Bergen- 310 Hillshire Dr., Annapolis, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chemia 612X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Benign Prostatic Hypertrophy (c) Unknown			INTERVAL BETWEEN ONSET AND DEATH Unknown
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Arteriosclerosis Heart Disease			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from June , 19 66 , to 8/15 , 19 66 , that (I) (we) last saw the deceased alive on 8/15 , 19 66 , and that death occurred at 6:00A.M. from causes and on the date stated above.			
22a. SIGNATURE Richard I. Hochman M.D.		22b. DATE SIGNED 8/16/66	22c. PHYSICIAN'S NAME (Type) Richard I. Hochman M. D.
22d. ADDRESS 59 Franklin St., Annapolis, Md.		23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	
23b. DATE THEREOF Aug. 17, 1966		23c. NAME OF CEMETERY OR CREMATORY Hillcrest Cemetery	
23d. LOCATION (City or Town) (County) (State) Annapolis Md.		24. FUNERAL DIRECTOR Beverley E. Hopping ADDRESS HOPPING FUNERAL HOME, Annapolis, Md.	
25a. REC'D BY REGISTRAR AUG 17 1966		25b. REGISTRAR'S SIGNATURE Charles Judge	

FOR STATE HEALTH DEPT.

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VR A15ME (5)
6M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10898

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10889

1 PLACE OF DEATH a. COUNTY <u>ANCO.</u> MARYLAND				2 USUAL RESIDENCE (Where deceased lived if institution. Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>ANCO.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Churchton</u>				c. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <u>Churchton</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Do A - Anne Arundel Gen.</u>				d. STREET ADDRESS			
3 NAME OF DECEASED (Type or print) <u>Alexander</u> First Middle Last <u>Officer</u>				4. DATE OF DEATH Month <u>8</u> Day <u>23</u> Year <u>1966</u>			
5 SEX <u>M</u>	6 COLOR OR RACE <u>N</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-15-96</u>		9 AGE (in years next birthday) <u>70</u> yrs		10 IF UNDER 1 YEAR Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Oystering</u>		10b. KIND OF BUSINESS OR INDUSTRY		11 BIRTHPLACE (State or foreign country) <u>MD.</u>		12 CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13 FATHER'S NAME <u>Wesley Officer</u>				14 MOTHER'S MAIDEN NAME <u>Ella Mae Hutton</u>			
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>yes WWII</u>		16 SOCIAL SECURITY NO		17 INFORMANT Address <u>Nettie Officer Churchton</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Drowning</u> DUE TO (b) <u>7293</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (c)							INTERVAL BETWEEN ONSET AND DEATH <u>Instant</u>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OF CONTRIBUTING CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <u>Summary in Rock Hall Creek</u>					
20c. TIME OF INJURY Month, Day, Year Hour <u>8:13</u> AM <u>8/23/66</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office building, etc.) <u>Rock Hall Creek</u>		20f. (City or town) (County) (State) <u>ANCO MD</u>	
21 I certify that I took charge of the remains described above; held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>E. Linhart</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>E. Linhart</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				Address (Street, city, town, or county)			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>8-28-1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Officer Cemetery</u>		23d. LOCATION (City or town) (County) (State) <u>Churchton MD</u>	
24. FUNERAL DIRECTOR <u>William Reese Jr.</u>				25a. REC'D BY REGISTRAR <u>Charles Judge</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	
				DATE <u>AUG 26 1966</u>			

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10899

CERTIFICATE OF DEATH

10890

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY A.A. Co. MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Md. b. COUNTY A.A. Co.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie		c. LENGTH OF STAY IN 1b 4 Hrs.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) North Arundel Hospital		e. STREET ADDRESS 107 Glenmont Avenue, Glen Burnie, Md.	
3. NAME OF DECEASED (Type or print) First William Middle NMN Last Pensmith		4. DATE OF DEATH Month August Day 29 Year 1966	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-10-97
9. AGE (In years last birthday) 69 yrs.		10. IF UNDER 1 Year Months 29 Days 19 Hours 66 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		10b. KIND OF BUSINESS OR INDUSTRY Ret.	
11. BIRTHPLACE (County & State, or foreign country) Balto., Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William Pensmith		14. MOTHER'S MAIDEN NAME Minnie Oberlein	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes WW1 WW 11		16. SOCIAL SECURITY NO. 214-14-0676	
17. INFORMANT Mrs. Genevieve Pensmith, same as 2		Address	
18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute Myocardial Infarction 4201 DUE TO (b) Arteriosclerosis, the Heart Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Diabetes Mellitus			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 8/29, 1966 , to 8/29, 1966 , that (I) (we) last saw the deceased alive on 8/29, 1966 , and that death occurred at 4:18 M. from causes and on the date stated above.			
22a. SIGNATURE H. T. C. HERLIHY M.D.		22b. DATE SIGNED 8/29/66	
22c. PHYSICIAN'S NAME (Type) H. T. C. HERLIHY		22d. ADDRESS 5 Central Ave., Glen Burnie	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 1 Sept. 66	
23c. NAME OF CEMETERY OR CREMATORY Baltimore National		23d. LOCATION (City or Town) (County) (State) Baltimore, Md.	
24. FUNERAL DIRECTOR Kirkley Funeral Home, Glen Burnie, Md.		25a. REC'D BY REGISTRAR DATE AUG 31 1966	
25b. REGISTRAR'S SIGNATURE Charles Judge			

HAC

• IS RESIDENCE ON A FARM?
YES ☐ NO ☒

Yes

IF UNDER 24 HRS.

12 CITIZEN OF, WHAT COUNTRY

LARRY JONES

ORMANT Address
SABETH C. POLKARD

CARCINOMA OF STOMACH

Conditions, if any, which } (b)
gave rise to immediate cause }
(a), stating the underlying } DUE TO
cause last. } (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

INTERVAL BETWEEN ONSET AND DEATH

1 YR

20a. ACCIDENT WAS UNDERLYING ☐
OR CONTRIBUTING ☐ CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year
Hour e.m.
p.m. 19

20d. INJURY OCCURRED
While at work ☐ Not While at work ☐

20a PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

201. (City or town)

[County]

(510)

21. I certify that (I) (this hospital) attended the deceased from MAY, 1958 to JULY, 1966, that (I) (we) last saw the deceased alive on JULY, 1966, and that death occurred at 9 P.M. from the causes and on the date stated above.

22. SIGNATURE _____

22. PHYSICIAN'S
NAME (Type)

M.D.

ATTEN
PHYS.

**MED.
DIRECTOR**

STAFF
PHYS.22b. DATE
SIGNED

23a. BURIAL, CREMATION, 23b. DATE THEREOF
REMOVAL (Specify) Cremation

REMOVAL (Specify)
BURIAL 18-10-69

23c/ NAME OF CEMETERY OR CREMATORY

Louden TARK

23d. LOCATION (City, town or county)

15Ahto,

{Site}

MD

24 FUNERAL DIRECTOR'S SIGNATURE

ADDRESS

25a. REC'D BY REGISTRAR

25b. REGISTRAR'S SIGNATURE _____

DATE AUG 9 1966

GISTRAR'S SIGNATURE
Charles Judge

TO HOSPITAL [redacted] **ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 [redacted] be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely [redacted] by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please ~~remove~~ carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
ISM 7-62

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10901

CERTIFICATE OF DEATH

10892

1. PLACE OF DEATH a. COUNTY <u>ANNE ARUNDEL COUNTY</u> <u>CROWNSVILLE</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>✓</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Crownsville</u>		c. LENGTH OF STAY IN lb <u>BALTIMORE</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>CROWNSVILLE STATE HOSPITAL</u>		d. STREET ADDRESS <u>1050 PENN. AVE</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>FLORENCE FRANKLIN REDDICK</u>		4. DATE OF DEATH Month Day Year <u>AUG. 13 1966</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-4-24</u>
9. AGE (In years, last birthday) <u>41</u> yrs		10. F UNDER 1 YEAR Months Days IF UNDER 24 HRS Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>	
13. FATHER'S NAME <u>EDWARD MITCHELL</u>		14. MOTHER'S MAIDEN NAME <u>MARY MITCHELL</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>ACUTE HEART FAILURE</u> <u>8-13</u> DUE TO (b) <u>UNKNOWN?</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>SCHIZOPHRENIA, PARANOID TYPE</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II at item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>8-10</u> , 19 <u>66</u> to <u>8-13</u> , 19 <u>66</u> that (I) (we) last saw the deceased alive on <u>8-13</u> , 19 <u>66</u> , and that death occurred at <u>1:50 P.M.</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>L. Benedict, M.D.</u>		22b. DATE SIGNED <u>8/15/66</u>	
22c. PHYSICIAN'S NAME (Type) <u>L. Benedict, M.D.</u>		22d. ADDRESS <u>Crownsville State Hospital, Maryland</u>	
23a. BURIAL, CREMATION, OR REMOVAL (Specify)	23b. DATE THEREOF <u>8/19/66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>St. Calvary</u>	23d. LOCATION (City or Town) (County) (State) <u>GA. Cemetery</u>
24. FUNERAL DIRECTOR <u>A. Holstead</u>		25a. REC'D BY REGISTRAR <u>1206 W North</u>	
25b. REGISTRAR'S SIGNATURE <u>James Judge</u>		DATE <u>AUG 16 1966</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10902

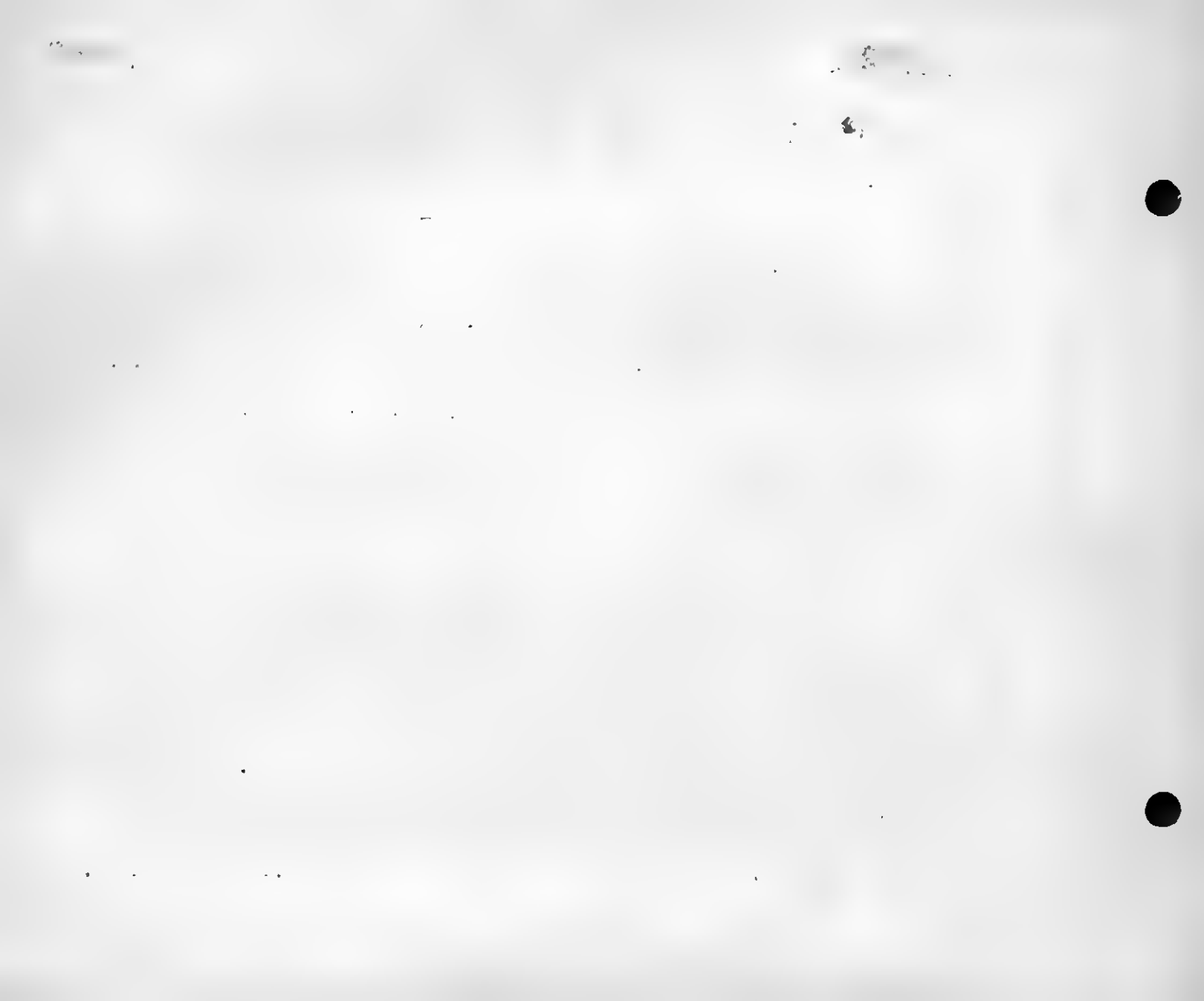
CERTIFICATE OF DEATH

10893

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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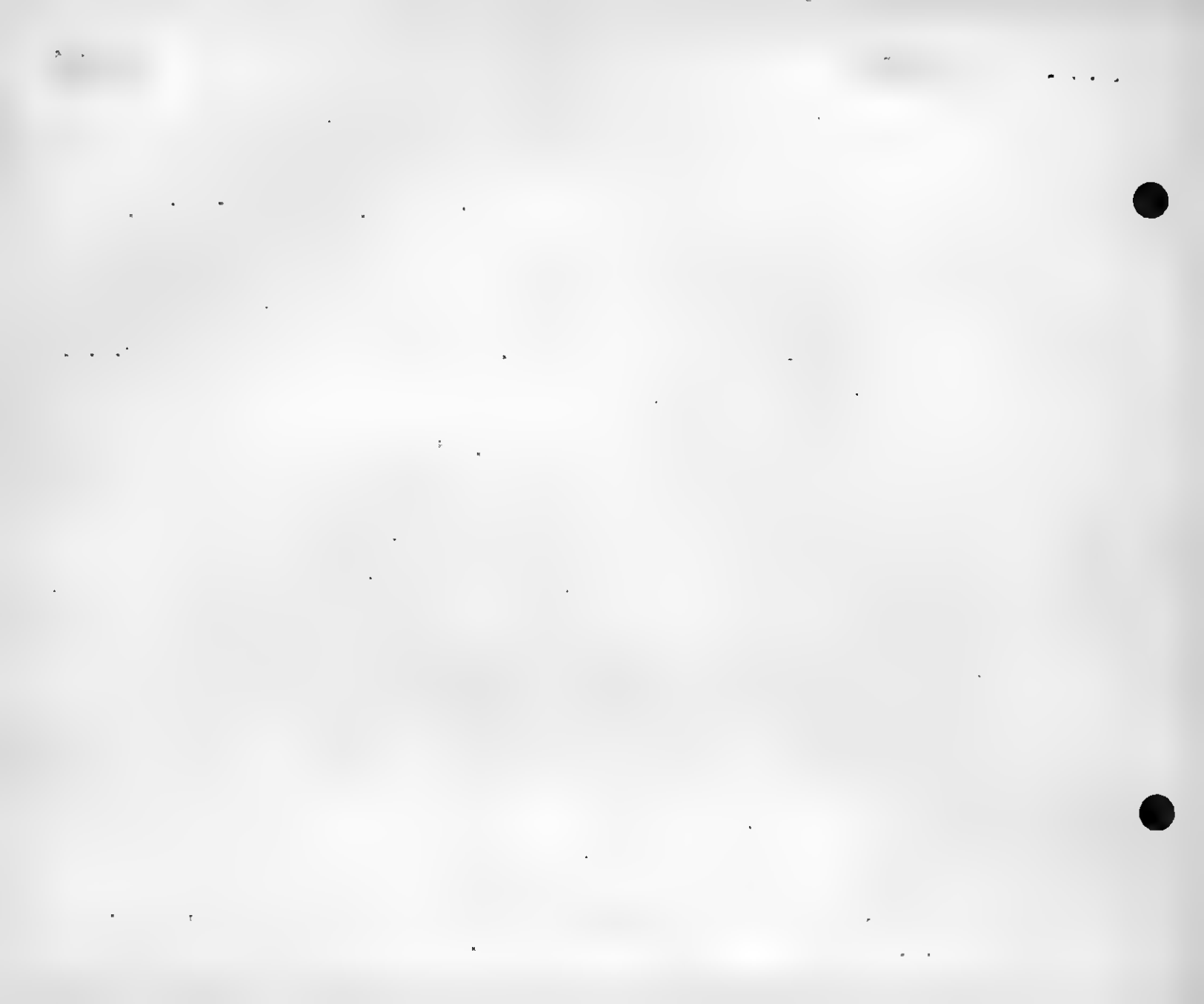
1 PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. LENGTH OF STAY IN 1b 2 days	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL - Annapolis
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Anne Arundel General Hospital		d. STREET ADDRESS Rt-2	e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
3 NAME OF DECEASED (Type or print) First Lanonia Middle Stinchcomb Last RIDOUT		4 DATE OF DEATH Month August Day 7 Year 1966	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 23, 1885
9. AGE (In years last birthday) 80 yrs		10. IF UNDER 1 YEAR Months 0 Days 0	11. IF UNDER 24 HRS. Hours 0 Min 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOME		10b. KIND OF BUSINESS OR INDUSTRY Housewife	
11. BIRTHPLACE (County & State, or foreign country) A.A. Cal Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME ALFRED A. Stinchcomb		14. MOTHER'S MAIDEN NAME SARAH ADAMS	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO	
17. INFORMANT FRANK E. Ridout #2		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebral Vascular Accident DUE TO Ischemia from blood clots Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost bleeding peptic ulcer DUE TO (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (the hospital) attended the deceased from Aug 6 , 19 66 , to Aug. 7 , 19 66 , that (I) (we) last saw the deceased alive on Aug 7 , 19 66 , and that death occurred at 5:15 M, from causes and on the date stated above.			
22a. SIGNATURE Stephen B. Hiltabidle		22b. DATE SIGNED Aug 7 '66	
22c. PHYSICIAN'S NAME (Type) Stephen B. Hiltabidle, MD.		22d. ADDRESS 121 Cathedral St., Annapolis, Md.	
23a. BURIAL, CREMATION—REMOVAL (Specify) BURIAL	23b. DATE THEREOF 8-9-66	23c. NAME OF CEMETERY OR CREMATORY WHITEHALL	23d. LOCATION (City or Town) (County) (State) St. Margarets MD.
24. FUNERAL DIRECTOR John M. Laylor & Sons Annapolis, Md.		25a. REC'D BY REGISTRAR DATE AUG 9 1966	
25b. REGISTRAR'S SIGNATURE Charles Judge			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
10902						10894					
1. PLACE OF DEATH a. COUNTY <i>Anne Arundel</i> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <i>MARYLAND</i> b. COUNTY <i>ANNE ARUNDEL</i>					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>GLEN BURNIE</i>				c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>GLEN BURNIE</i>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>North Arundel Hospital</i>						d. STREET ADDRESS <i>522 BALTO. & ANNAPOLIS BLVD.</i>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>ROBERT L RINGGOLD Sr</i>						4. DATE OF DEATH Month <i>August</i> Day <i>21</i> Year <i>1966</i>					
5. SEX <i>Male</i>		6. COLOR OR RACE <i>White</i>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>11/11/86</i>		9. AGE (In years last birthday) <i>79</i> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>VAULE HOUSE OPERATOR</i>				10b. KIND OF BUSINESS OR INDUSTRY <i>(RET) G & E CO.</i>		11. BIRTHPLACE (County & State, or foreign country) <i>MARYLAND</i>				12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>(UNKNOWN) RINGGOLD</i>						14. MOTHER'S MAIDEN NAME <i>UNKNOWN</i>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>NO</i>				16. SOCIAL SECURITY NO. <i>212/05/4569</i>		17. INFORMANT <i>MRS. Hilda Ringgold</i>				Address <i>Same as #2</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Left ventricular failure</i> DUE TO (b) <i>Acute Pulmonary Edema</i> DUE TO (c) <i>Hypertensive Cardiovascular Disease</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										INTERVAL BETWEEN ONSET AND DEATH <i>Hours</i> <i>Days</i> <i>Year.</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <i>8/12</i> , 19 <i>66</i> to <i>8/21</i> , 19 <i>66</i> , that (I) (we) last saw the deceased alive on <i>8/21</i> , 19 <i>66</i> , and that death occurred at <i>3:20 PM</i> from the causes and on the date stated above.											
22a. SIGNATURE <i>Max C Frank MD</i>						M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <i>8/21/66</i>			
22c. PHYSICIAN'S NAME (Type) <i>MAX C FRANK MD</i>						22d. ADDRESS <i>425 SE Arden Hwy Glen Burnie</i>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>		23b. DATE THEREOF <i>8/24/66</i>		23c. NAME OF CEMETERY OR CREMATORY <i>GLEN HAVEN MEM'L PARK</i>		23d. LOCATION (City, town or county) (State) <i>GLEN BURNIE, MD.</i>					
24. FUNERAL DIRECTOR <i>R.V. SINGLETON</i>				ADDRESS <i>GLEN BURNIE, MD.</i>		25a. REC'D BY REGISTRAR <i>AUG 25 1966</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			



10904

CERTIFICATE OF DEATH

10895

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and page 3 after death.

1 PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c LENGTH OF STAY IN 7b Annapolis	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Anne Arundel General Hospital		d. STREET ADDRESS 302 N. Glen Ave.,	
3. NAME OF DECEASED (Type or print) First Anna Middle Mildred Last ROGERS		4 DATE OF DEATH Month August Day 30 Year 1966	
5 SEX Female	6. COLOR OR RACE White	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH Nov. 11, 1897
9 AGE (In years last birthday) 68 yrs		10 IF UNDER 1 YEAR Months 68 Days 68 Hours 68 Min. 68	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOME		10b KIND OF BUSINESS OR INDUSTRY HOUSEWIFE	
11 BIRTHPLACE (County & State, or foreign country) SHADY SIDE, Maryland		12 CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Wm M. Owings		14. MOTHER'S MAIDEN NAME Lucy J. Simmons	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16 SOCIAL SECURITY NO JAMES E. ROGERS #2	
17 INFORMANT JAMES E. ROGERS		Address #2	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): DUE TO Acute pulmonary edema Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Acute myocardial infarction (c)		INTERVAL BETWEEN ONSET AND DEATH Days Weeks	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19 WAS A JTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (to hospital) attended the deceased from 8/15 , 19 66 , to Aug. 30 , 19 66 , that (I) (to funeral director) saw the deceased alive on Aug. 30 , 19 66 , and that death occurred at 8:00 PM , from causes and on the date stated above.			
22a. SIGNATURE General Church		22b. DATE SIGNED 8/31/66	
22c. PHYSICIAN'S NAME (Type) Gunnar Edward		22d. ADDRESS 121 Cathedral St. Annapolis, Md.	
23a BURIAL, CREMATION, REMOVAL (Specify)	23b DATE THEREOF	23c NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
BYE/AL	9-2-66	CEDAR Bluff	ANNAPODIS MD.
24. FUNERAL DIRECTOR John M. Taylor & Sons		25a. REC'D BY REGISTRAR DATE SEP 2 1966	
25b. REGISTRAR'S SIGNATURE Charles Judge			

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VR A15 (4)
20 M 1/66

10905

CERTIFICATE OF DEATH

10896

1 PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institut on Residence before admission) a. STATE MD b. COUNTY ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Laurel		c. LENGTH OF STAY IN 1b 59 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington, D. C.			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) D. C. Children's Center Hospital				d. STREET ADDRESS 15 - 58th St., N. E.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First Bobby Middle Gene Last Royal				4. DATE OF DEATH Month August Day 12 Year 1966			
5 SEX Male	6 COLOR OR RACE Negro	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 10-17-51	9 AGE (In years last birthday) 14 13/4 yrs	10 IF UNDER 1 YEAR Months 13 Days 13 Hours 13 Min.		11 IF UNDER 24 HRS Months 13 Days 13 Hours 13 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Institutionalized		10b. KIND OF BUSINESS OR INDUSTRY ---		11 BIRTHPLACE (County & State, or foreign country) North Carolina		12 CITIZEN OF WHAT COUNTRY? USA	
13 FATHER'S NAME James A. Royal				14. MOTHER'S MAIDEN NAME Martha O. Royal			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16 SOCIAL SECURITY NO.		17 INFORMANT Children's Center Hospital, Laurel, Md			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Aspiration pneumonia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) Mental retardation (Schilder's disease) DUE TO (c) ---							INTERVAL BETWEEN ONSET AND DEATH 1 day Since birth
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1B.)					
20c TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from June 13 , 19 66 , to August 12, 1966 , that (I) (we) last saw the deceased alive on August 12, 1966 , and that death occurred at 10:15 AM from causes noted on and on the date stated above.							
22a. SIGNATURE George T. Economos M.D.				ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED August 12, 1966	
22c. PHYSICIAN'S NAME (Type) GEORGE T. ECONOMOS, M. D.				22d. ADDRESS Children's Center Hospital, Laurel, Md			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF 8-18-66		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State) 11th St. Laurel, Md	
24. FUNERAL DIRECTOR HALL BROS. 621 Fla. Ave. N.W.				ADDRESS		25a. REC'D BY REGISTRAR AUG 17 1966	
						25b. REGISTRAR'S SIGNATURE James Judge	

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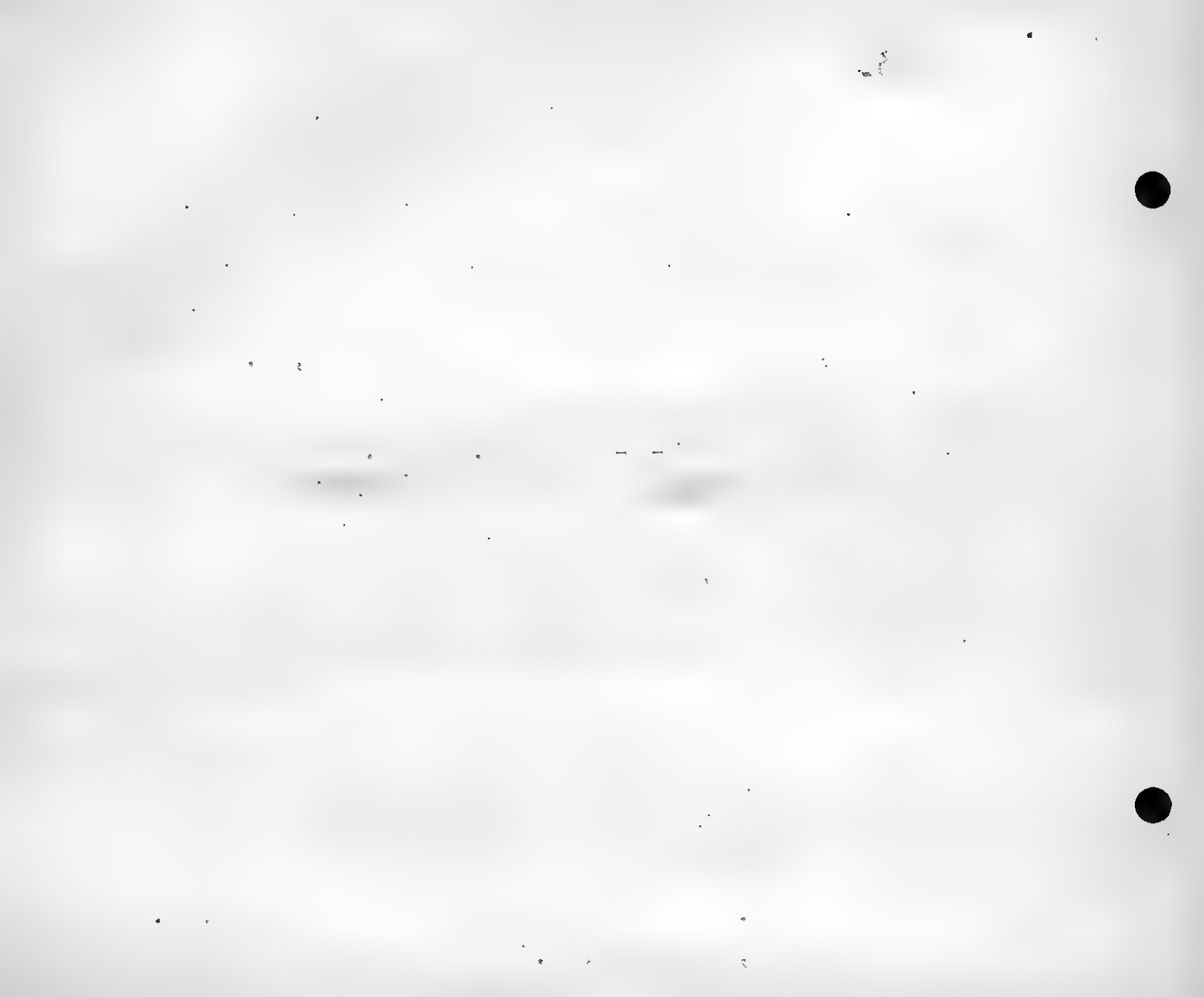
VR A15 (4)
20M 1/65

739

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel County</u> <u>CROWNSVILLE</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>AA</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>CROWNSVILLE STATE HOSPITAL</u>		d. STREET ADDRESS <u>1009 BALTO-ANNAP. BLVD</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>GEORGE CHARLES SHEPPARD</u>		4. DATE OF DEATH Month Day Year <u>8 20 19 66</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4-18-1898</u>
9. AGE (In years last birthday) <u>68</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Sheet Metal Worker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Philadelphia, Pa.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>JOHN SHEPPARD</u>		14. MOTHER'S MAIDEN NAME <u>ANNA Rati</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>Yes WW1</u>		16. SOCIAL SECURITY NO. <u>705-07-2378</u>	
17. INFORMANT <u>Mrs. Ellen M. Sheppard, same as 2</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>PNEUMONIA</u> DUE TO (b) <u>HEART FAILURE</u> DUE TO (c) <u>GEN. ARTERIO SCLEROSIS</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>CHRONIC BRAIN SYNDROME SEC. CEREBRAL ARTERIO SCLEROSIS</u>		19. WAS AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>8-1</u> , 19 <u>66</u> to <u>8-20</u> , 19 <u>66</u> that (I) (we) last saw the deceased alive on <u>8-20</u> , 19 <u>66</u> , and that death occurred at <u>9:30</u> M, from the causes and on the date stated above.			
22a. SIGNATURE <u>L. BENEDICT M.D.</u>		22b. DATE SIGNED <u>8/20/66</u>	
22c. PHYSICIAN'S NAME (Type) <u>L. BENEDICT M.D.</u>		22d. ADDRESS <u>Crownsville State Hospital</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>24 Aug. 66</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Baltimore National</u>		23d. LOCATION (City, town or county) (State) <u>Baltimore, Md.</u>	
24. FUNERAL DIRECTOR <u>Kirkley Funeral Home, Glen Burnie, Md.</u>		25a. REC'D BY REGISTRAR <u>AUG 23 1966</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			



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VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
10907									
10898									
1. PLACE OF DEATH a. COUNTY <u>AA</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>BROOKLYN PK.</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>303 Audrey Ave</u>					2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>aa</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Brooklyn PK</u> d. STREET ADDRESS <u>303 Audrey Ave</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First Middle Last <u>Harry G. Simmont</u>			4. DATE OF DEATH Month Day Year <u>8 9 1966</u>						
5. SEX <u>M</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Aug 10, 1894</u>		9. AGE (In years last birthday) <u>71</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Am. B.T. Co.</u>		11. BIRTHPLACE (County & State, or foreign country) <u>MD</u>			12. CITIZEN OF WHAT COUNTRY?		
13. FATHER'S NAME <u>Harry T. Simmont</u>					14. MOTHER'S MAIDEN NAME <u>Memie Boman</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>			16. SOCIAL SECURITY NO.		17. INFORMANT <u>Fanny</u>		Address <u>John</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARCINOMA OF LUNG</u> DUE TO (b) <u>MALNUTRITION.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>ASCVD.</u>								INTERVAL BETWEEN ONSET AND DEATH <u>28 YRS</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <u>5/1</u> , 19 <u>65</u> , to <u>8/10</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>8/9</u> , 19 <u>66</u> , and that death occurred at <u>11:30</u> AM, from the causes and on the date stated above.									
22a. SIGNATURE <u>Leymond W. Lott MD</u>					ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>8/10/66</u>		
22c. PHYSICIAN'S NAME (Type) <u>LEYMOND W. LOTT MD.</u>					22d. ADDRESS <u>529 CAMP MEADE, RD.</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <u>8-13-66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Sacred Heart</u>			23d. LOCATION (City, town or county) (State) <u>Bundick Md</u>		
24. FUNERAL DIRECTOR <u>Mc Culley Funeral Home</u>					ADDRESS <u>237 P. Popoca Ave</u>		25a. REC'D BY REGISTRAR <u>John</u>		25b. REGISTRAR'S SIGNATURE <u>John</u>
DATE <u>AUG 15 1966</u>									

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CORONER NOTIFIED & WILL APPROVE CHECK

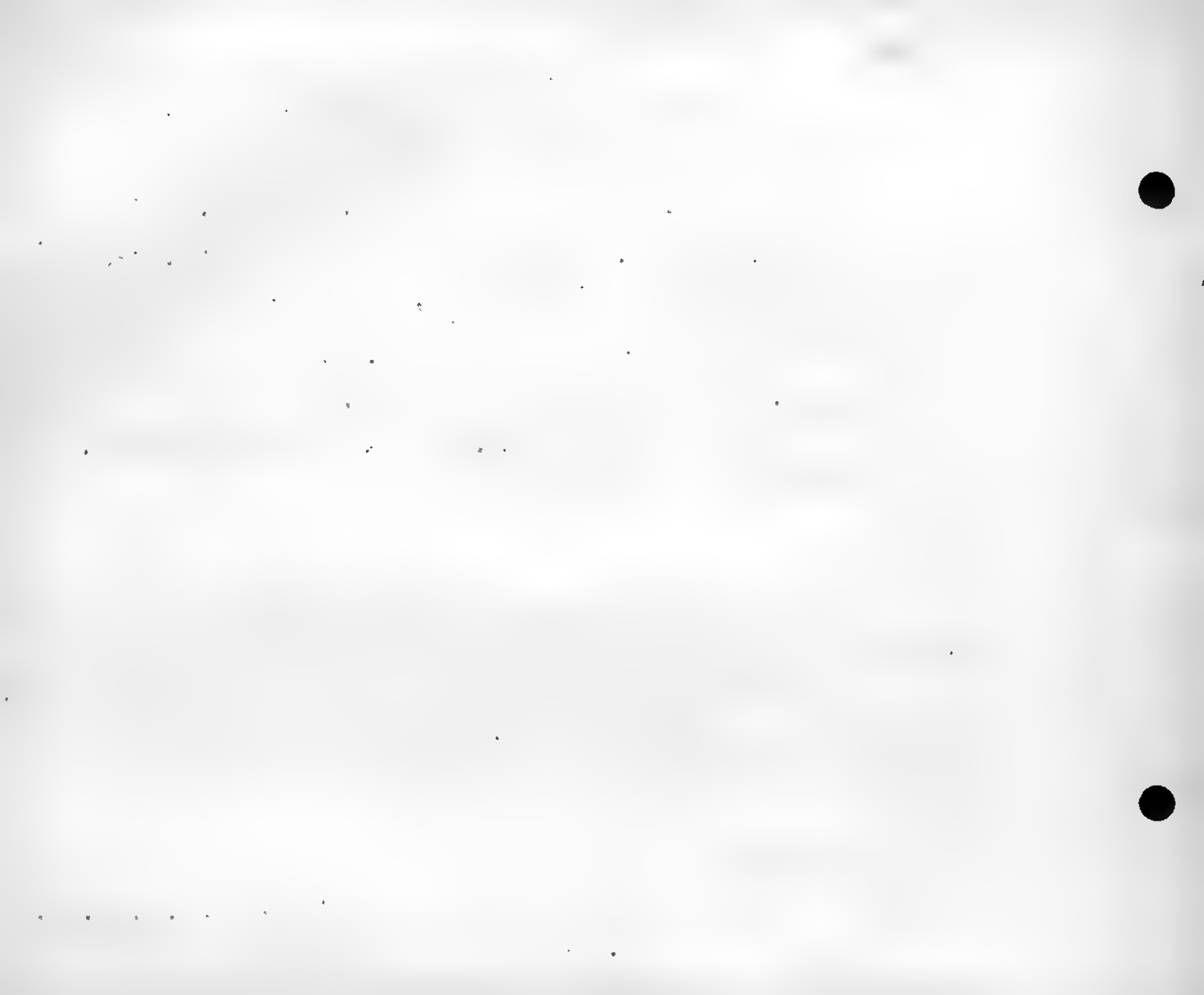
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18											
10908 CERTIFICATE OF DEATH 10899											
Reg. Dist. No.											
1. PLACE OF DEATH a. COUNTY ANNE ARUNDEL MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FT. GEORGE G. MEADE					c. LENGTH OF STAY IN 1b ??						
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 9800 SALAGE ROAD					d. STREET ADDRESS 5803 GREEN TREE RD.						
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print) First ALBERT Middle WEBSTER Last SMALL					4. DATE OF DEATH Month AUGUST Day 9 Year 1966						
5. SEX MALE		6. COLOR OR RACE CAUCASIAN		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 22 DEC. 1910		9. AGE (In years last birthday) 55 yrs.			
						IF UNDER 1 YEAR Months 7 Days 17		IF UNDER 24 HRS Hours Min. 			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ADMINISTRATOR					10b. KIND OF BUSINESS OR INDUSTRY DEPT. OF DEFENSE		11. BIRTHPLACE (State or foreign country) WASHINGTON D.C.		12. CITIZEN OF WHAT COUNTRY? UNITED STATES		
13. FATHER'S NAME ALBERT SMALL					14. MOTHER'S MAIDEN NAME ELSIE M. WEBSTER						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) NO					16. SOCIAL SECURITY NO. 577-01-9843		17. INFORMANT PERSONNEL RECORDS			Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION 42A1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE DUE TO (c) 										INTERVAL BETWEEN ONSET AND DEATH 5 minutes 7 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 					20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from NONE , 19 , to NONE , 19 , that I last saw the deceased alive on 9 AUGUST , 19 66 , and that death occurred at 2 PM M, from the causes and on the date stated above.											
ACTUAL SIGNATURE Francis C. Kirchner					ADDRESS (Street, city or town, state) FT. GEORGE G. MEADE, MD DATE SIGNED 9 Aug 66						
PHYSICIAN'S NAME (Type) FRANCIS C. KIRCHNER, M.D.					FT. GEORGE G. MEADE, MARYLAND 09 AUG 66						
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial					22b. DATE THEREOF 8/12/1966		22c. NAME OF CEMETERY OR CREMATORY Rock Creek Cemetery		22d. LOCATION (City, town, or county) (State) Washington D. C.		
23. FUNERAL DIRECTOR'S SIGNATURE Robert L. Humphrey					ADDRESS Bethesda, Maryland		24a. REC'D BY REGISTRAR AUG 11 1966		24b. REGISTRAR'S SIGNATURE Charles Judge		

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M
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
10900
CERTIFICATE OF DEATH
10900

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Millersville</u> c. LENGTH OF STAY IN b. <u>96</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Knollwood Manor Nursing Home</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> d. STREET ADDRESS <u>1521 S. Hanover St.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) First <u>Edna</u> Middle <u>M.</u> Last <u>Staffer</u>		4. DATE OF DEATH Month <u>Aug.</u> Day <u>12</u> Year <u>1966</u>		5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>May 17, 1893</u>		9. AGE (In years last birthday) <u>73</u> yrs. IF UNDER 1 YEAR: Months <u>7</u> Days <u>12</u> Hours <u>15</u> Min. IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>At Home</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Balto., Md.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>			
13. FATHER'S NAME <u>Benjamin F. Russell</u>				14. MOTHER'S MAIDEN NAME <u>Mary A. Cole</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service)				16. SOCIAL SECURITY NO. <u>604 Ashington Rd.</u>	
17. INFORMANT <u>Mrs. Naomi Smith</u>				18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Adenos carcinoma of rectum</u> 154X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. INTERVAL BETWEEN ONSET AND DEATH					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from <u>December, 1966</u> to <u>August, 1966</u> , that (I) (we) last saw the deceased alive on <u>Aug 10</u> 19 <u>66</u> , and that death occurred at <u>12 PM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>Ricardo Lozada</u>				22b. DATE SIGNED				22c. PHYSICIAN'S NAME (Type) <u>RICARDO LOZADA</u>				22d. ADDRESS <u>1225 Schalk St. Bldg 1421220</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				23b. DATE THEREOF <u>8 16 1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Glen Haven</u>		23d. LOCATION (City, town or county) (State) <u>Glen Burnie, A. A. Co. Md.</u>					
24. FUNERAL DIRECTOR <u>Mc Gully</u>				ADDRESS <u>130 E. Fort Ave</u>				25a. REC'D BY REGISTRAR <u>AUG 15 1966</u>				25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A.5ME (5)
5M 1/65

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>B.A. CO</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Pa</u> b. COUNTY <u>Philadelphia</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Philadelphia</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Philadelphia</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>D.O.A. - A.A. General Hosp.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>WALKER</u>		4. DATE OF DEATH Month <u>8</u> Day <u>23</u> Year <u>1966</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-15-1886</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LABORER RET</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>DISSTON PORTER D.V.</u>	
11. BIRTHPLACE (State or foreign country) <u>POLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>STRAUSS</u>		14. MOTHER'S MAIDEN NAME <u>UNK.</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>—</u>		16. SOCIAL SECURITY NO. <u>164-07-4463</u>	
17. INFORMANT <u>CHESTER STRAUSS</u>		Address <u>4312 ARLENDO ST. PHILA. PENN.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>intercranial hemorrhage</u> <u>4300</u> DUE TO (b) <u>—</u> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. DUE TO (c) <u>—</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u>—</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>E. Linhart</u>		22. DATE SIGNED <u>8/23/66</u>	
EXAMINER'S NAME (Type) <u>E. Linhart</u>		M.O. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) <u>—</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>AUG 29-1966</u>	23c. NAME OF CEMETERY OR CREMATORY <u>MOST HOLY REDEEMER CEM.</u>	23d. LOCATION (City, town or county) (State) <u>PHILADELPHIA PENN.</u>
24. FUNERAL DIRECTOR <u>JOHN M. TAYLOR - SONS ANNAPOLIS MD.</u>		25a. REC'D BY REGISTRAR <u>—</u> 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10911

CERTIFICATE OF DEATH

10902

1 PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. LENGTH OF STAY IN 1b 1 day	
d. NAME OF HOSPITAL, OR INSTITUTION (If not in hospital, give street address) Anne Arundel General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First Middle Last Lottie Marian SUITE		4 DATE OF DEATH Month Day Year August 25 19 66	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 1, 1891
9. AGE (in years last birthday) 75 yrs		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk		10b. KIND OF BUSINESS OR INDUSTRY Beach Resort	
11. BIRTHPLACE (County & State, or foreign country) Annapolis Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Anton Steiner		14. MOTHER'S MAIDEN NAME Annie Herold	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO 220-16-8479	
17. INFORMANT Agnes Hardesty - same as #2 above		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Shock 586X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Gram-negative septicemia (c) Ruptured gallbladder		INTERVAL BETWEEN ONSET AND DEATH 5 minutes 4 hours? 3 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Obesity		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (the hospital) attended the deceased from 24 August, 1966 , to Aug. 25, 1966 that (I) (we) saw the deceased alive on Aug. 25, 1966 and that death occurred at 4:55 PM from causes and on the date stated above.			
22a. SIGNATURE Charles W. Kinzer		22b. DATE SIGNED 27 Aug. 1966	
22c. PHYSICIAN'S NAME (Type) Charles W. Kinzer, M. D.		22d. ADDRESS South River Medical Center Edgewater, Maryland 21037	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Aug. 29, 1966	23c. NAME OF CEMETERY OR CREMATORY All Hallows Cemetery	23d. LOCATION (City or Town) (County) (State) Birdsville A.A. Md.
24. FUNERAL DIRECTOR Beverly E. Hopping Hopping Funeral Home		25a. REC'D BY REGISTRAR DATE AUG 30 1966	
25b. REGISTRAR'S SIGNATURE Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 and 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

APPROVED BY DR. LINDHART

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
10912											
10903											
1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>					
b. CITY OR TOWN (If outside of corporate limits, write RURAL and give nearest town) <u>RT 1 Box 365 Edgewater</u>						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Edgewater</u>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Mayo Road</u>						d. STREET ADDRESS <u>RT 1 Box 365 Mayo Road</u>					
3. NAME OF DECEASED (Type or print) First <u>Warren</u> Middle <u>Lee</u> Last <u>Suitt, Jr.</u>						4. DATE OF DEATH Month <u>8</u> Day <u>23</u> Year <u>1966</u>					
5. SEX <u>Male</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>7-30-66</u>		9. AGE (In years last birthday) yrs. <u>23</u>		IF UNDER 1 YEAR Months <u>23</u> Days <u>23</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>—</u>						10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>					
11. BIRTHPLACE (County & State, or foreign country) <u>Anne Arundel County, Md.</u>						12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>					
13. FATHER'S NAME <u>Warren Lee Suitt</u>						14. MOTHER'S MAIDEN NAME <u>Edwards</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>—</u>						16. SOCIAL SECURITY NO. 17. INFORMANT <u>Warren Lee Suitt - father</u>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Asphyxia</u>											
DUE TO (b) <u>Aspiration of respiratory Mucous</u>											
Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. <u>Unknown</u>											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Fed at 11 PM, found with face down at 6:50 AM</u>											
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. (City or town) (County) (State) <u>Edgewater</u>					
21. I certify that (I) (this hospital) attended the deceased from <u>7/30</u> , 19 <u>66</u> , to <u>8/23</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>8/23</u> , 19 <u>66</u> , and that death occurred at <u>6:50</u> AM, from the causes and on the date stated above.											
22a. SIGNATURE <u>Sylvia M. Lim</u> M.D.						22b. DATE SIGNED <u>8/23/66</u>					
22c. PHYSICIAN'S NAME (Type) <u>Sylvia M. Lim</u>						22d. ADDRESS <u>RT 1 Box 244 Edgewater, Md.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>8-24-66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>MAYO MEMORIAL</u>		23d. LOCATION (City, town or county) (State) <u>MAYO A.A. MD.</u>					
24. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Taylor & Sons</u>						25. REC'D BY REGISTRAR DATE <u>AUG 26 1966</u>					
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>											

10913

CERTIFICATE OF DEATH

10904

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie		c. LENGTH OF STAY IN 16 /////		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) North Arundel Hosp				d. STREET ADDRESS 804 Glenview Ave. S/W		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last FREDERICK A. TEPPER, Sr.				4. DATE OF DEATH Month Day Year August 21 1966			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 16, 1909		9. AGE (In years last birthday) yrs 56	F UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min	
10a. USUA. OCCUPATION (Give kind of work done during most of working life, even if retired) Suplt.		10b. KIND OF BUSINESS OR INDUSTRY AA Co. Public Wks. Baltimore, Maryland		11. BIRTHPLACE (County & State, or foreign country) USA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME L.C. Tepper				14. MOTHER'S MAIDEN NAME Emma A. Bussey			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No None		16. SOCIAL SECURITY NO 217-16-6673		17. INFORMANT Address Mrs. Grace M. Tepper (wife) Same as #2			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio-Vascular Disease 4221 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) _____ (c) _____						INTERVAL BETWEEN ONSET AND DEATH 8-10	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Sept , 19 66 , to Aug 21 , 19 66 , that (I) (we) last saw the deceased alive on Aug 21 , 19 66 , and that death occurred at 6:30 PM , from causes and on the date stated above.							
22a. SIGNATURE Chas. L. Ball Jr.				M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 8/22/66	
22c. PHYSICIAN'S NAME (Type) CHARLES L. BALL JR.				22d. ADDRESS Smithsonian Bldg			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Aug. 25, 1966		23c. NAME OF CEMETERY OR CREMATORY Glen Haven Memorial Pk.		23d. LOCATION (City or Town) (County) (State) Glen Burnie, Maryland	
24. FUNERAL DIRECTOR Richard V. Singleton				25a. REC'D BY REGISTRAR Glen Burnie, Md		25b. REGISTRAR'S SIGNATURE AUG 25 1966	

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10914

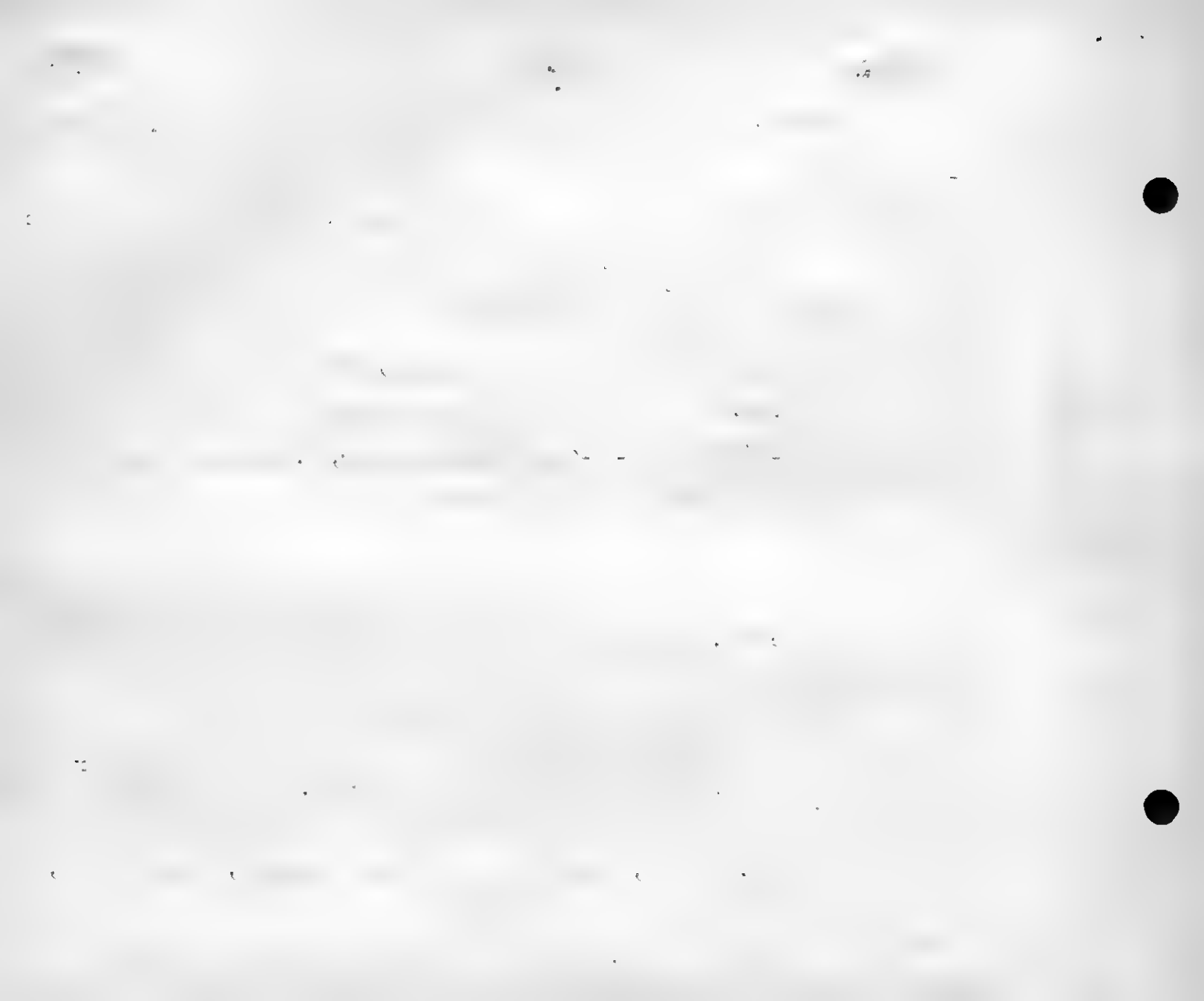
CERTIFICATE OF DEATH

10905

1 PLACE OF DEATH a. COUNTY ANNE ARUNDEL MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE MARYLAND b. COUNTY ANNE ARUNDEL	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FT GEO G MEADE		c. LENGTH OF STAY IN lb 10 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) KIMBROUGH ARMY HOSPITAL		d. STREET ADDRESS 1474 BUERGER STREET	
3 NAME OF DECEASED (Type or print) First HERMAN Middle CARL Last TREUNER		4. DATE OF DEATH Month AUGUST Day 23 Year 19 66	
5 SEX MALE	6 COLOR OR RACE WHITE	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 23 June 1880
9 AGE (In years last birthday) yrs 86		IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY None	
11 BIRTHPLACE (County & State, or foreign country) Saalfeld, Germany		12 CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME unr TREUNER		14. MOTHER'S MAIDEN NAME MARIE RIEMAN	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes 6/21/09-6/30/42		16. SOCIAL SECURITY NO 214-48-2471	
17 INFORMANT Herman Treuner, Jr. (same as item #2)		Address	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CEREBRAL ARTERIOSCLEROSIS 334x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) DUE TO (c) DUE TO		INTERVAL BETWEEN ONSET AND DEATH 10 DAYS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) Acute pulmonary edema, arteriosclerotic heart disease		19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that he (this hospital) attended the deceased from 13 Aug , 19 66 , to 23 Aug , 19 66 that he (we) last saw the deceased alive on 23 Aug , 19 66 , and that death occurred at 8:30 a.m. from causes on and on the date stated above.			
22a SIGNATURE <i>Bernard T. Kravitz</i>		22b. DATE SIGNED 23 Aug 66	
22c. PHYSICIAN'S NAME (Type) BERNARD T. KRAVITZ, CPT, MC		22d ADDRESS KIMBROUGH ARMY HOSP, FT GEO G MEADE, MD	
23a BURIAL, CREMATION, REMONATION BURIAL	23b. DATE THEREOF Aug. 26, 1966	23c. NAME OF CEMETERY OR CREMATORY BALTIMORE NATIONAL CEM.	23d LOCATION (City or Town) (County) (State) BALTIMORE, MARYLAND
24. FUNERAL DIRECTOR Harold S. Wade, 550 Wash. Blvd., Laurel, Maryland		25a. REC'D BY REGISTRAR DATE SEP 7 1966	
		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. ~~They~~ Please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or reburial, and in any event, within 72 hours after death.



FOR STATE
HEALTH DEPT.

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10916

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10906

1 PLACE OF DEATH a COUNTY <u>A.A. CO.</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a STATE <u>MD</u> b. COUNTY <u>HACU</u>	
b CITY OR TOWN (If outside of corporate limits, write RURAL and give nearest town) <u>Glen Burnie</u>		c LENGTH OF STAY IN 1b <u>Glen Burnie</u>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>NORTH ARUNDEL</u>		e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First <u>Eden</u> Middle <u>B.</u> Last <u>Turner</u>		4 DATE OF DEATH Month <u>8</u> Day <u>4</u> Year <u>1966</u>	
5 SEX <u>M</u>	6 COLOR OR RACE <u>W</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>8/23/1897</u>
9 AGE (In years last birthday) <u>68</u> yrs		10 UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min <u> </u>	
11 US. AL. OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Chauffeur (ret.)</u>		12b KIND OF BUSINESS OR INDUSTRY <u>Anne Arundel Co.</u>	
13 BIRTHPLACE (State or foreign country) <u>Odenton, Maryland</u>		14 CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
15 FATHER'S NAME <u>John H. Turner</u>		16 MOTHER'S MAIDEN NAME <u>Mary Lowman</u>	
17 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>		18 SOCIAL SECURITY NO <u>217-09-3388</u>	
19 INFORMANT <u>Mr. Lennie D. Romine (Brother)</u>		20 ADDRESS <u>P.O. Box 495 Odenton, Md.</u>	
21b CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Pulmonary edema</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <u>XXXX</u> (b) <u> </u> (c) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH <u>50 MIN</u>	
22 PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u> </u>		23 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
24a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		25b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <u> </u>	
26c TIME OF INJURY Month, Day, Year Hour <u> </u> a.m. <u> </u> p.m. <u> </u> 19 <u> </u>		27d INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work <input type="checkbox"/>	
28e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>		29f (City or town) (County) (State) <u> </u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>E. Linhardt</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>E. Linhardt</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22. DATE SIGNED <u>8/4/66</u>	
Address (Street, city, town, or county) <u> </u>			
30a BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	31b DATE THEREOF <u>Aug. 8, 1966</u>	32c NAME OF CEMETERY OR CREMATORY <u>Epiphany Episcopal Ch. Cem.</u>	
33 LOCATION (City or Town) (County) (State) <u>Odenton, A.A. Co., Md.</u>			
34 FUNERAL DIRECTOR <u>R. V. Singleton</u>		35 ADDRESS <u>Singleton Funeral Home, Glen Burnie, Md.</u>	
36 REC'D BY REGISTRAR <u> </u>		37 REGISTRAR'S SIGNATURE <u>Charles Judge</u>	
DATE <u>AUG 9 1966</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

10917

10907

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. These pages remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ft. Geo. G. Meade</u>		c. LENGTH OF STAY IN ID <u>7/17/66-8/26/66</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ft. George G. Meade</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Kimbrough Army Hospital</u>				d. STREET ADDRESS <u>7228-F Hall St.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>MARLANNE</u> Middle <u>UNDERWOOD</u> Last <u>UNDERWOOD</u>				4. DATE OF DEATH Month <u>Aug.</u> Day <u>26</u> Year <u>19 66</u>			
5. SEX <u>F.</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>May 15, 1925</u>		9. AGE (In years last birthday) <u>41</u> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Saarlouis, France</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Johann Theobald</u>				14. MOTHER'S MAIDEN NAME <u>Maria Zimmerman</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>465-56-5288</u>		17. INFORMANT <u>Charles Underwood</u> Address <u>same as #2 above</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Aspiration Pneumonitis</u> DUE TO (b) <u>Metastatic widespread malignant</u> DUE TO (c) <u>Melenoma</u> CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last.						INTERVAL BETWEEN ONSET AND DEATH <u>12 hrs.</u> <u>3 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>July 17</u> , 19 <u>66</u> , to <u>Aug. 26</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>Aug. 26</u> , 19 <u>66</u> , and that death occurred at <u>11:10</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>Jerry G. Price, M.D.</u>				22b. DATE SIGNED <u>Aug. 26, 1966</u>		22c. PHYSICIAN'S NAME (Type) <u>Jerry G. Price, Capt., M.D.</u>	
22d. ADDRESS <u>Kimrough Army Hospital, Ft. Meade, Md.</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Aug. 30, 1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Baltimore National Cemetery, Baltimore</u>		23d. LOCATION (City, town or county) (State)	
24. FUNERAL DIRECTOR <u>Beverley E. Hopping</u> <u>Hopping Funeral Home</u>				25. REG'D BY REGISTRAR <u>Charles Judge</u>			
25b. ADDRESS <u>Annapolis, Md.</u>				25c. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			
DATE <u>AUG 30 1966</u>							

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10918

CERTIFICATE OF DEATH

10908

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove coroner papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Maryland</u> COUNTY <u>1</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Crownsville</u>		c. LENGTH OF STAY IN TB <u>1 month</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Crownsville State Hosp.</u>		d. STREET ADDRESS <u>3417 Clavmont Ave.</u>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Tennie</u> Middle <u>Villella</u> Last <u>Villella</u>		4. DATE OF DEATH Month <u>August</u> Day <u>4th</u> Year <u>1966</u>	
5. SEX <u>Fe</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9/23/1900</u>
9. AGE (In years last birthday) <u>65</u> yrs		10. IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u>	11. IF UNDER 24 HRS Hours <u>0</u> Mins. <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country) <u>U.S.</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		13. FATHER'S NAME <u>John Gara Polo.</u>	
14. MOTHER'S MAIDEN NAME <u>Cerniaca</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>	
16. SOCIAL SECURITY NO <u>215-07-45126</u>		17. INFORMANT <u>Hospital Record.</u> Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>4415X</u> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Chronic Brain Syndrome; Cerebral Vascular Disease</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>20th June, 1966</u> , to <u>4th August 1966</u> , that (I) (we) lost saw the deceased alive on <u>4th August 1966</u> , and that death occurred at <u>7:15 A.M.</u> from causes and on the date stated above.			
22a. SIGNATURE <u>Alvin Thompson</u>		22b. DATE SIGNED <u>5/4/66</u>	
22c. PHYSICIAN'S NAME (Type) <u>Alvin Thompson</u>		22d. ADDRESS <u>Crownsville State Hosp.</u>	
23a. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>8/8/66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Oaklawn Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Baltimore Maryland</u>
24. FUNERAL DIRECTOR <u>Joseph N Zannone</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>	
25b. ADDRESS <u>263 S. Conkling St.</u>		25c. DATE <u>AUG 8 1966</u>	

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If only delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PH-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10912

10909

1. PLACE OF DEATH a. COUNTY AA CO. MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institut on- Residence before adm ssion) a. STATE MD b. COUNTY AA CO.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pasadena		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pasadena	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) D.O.A - NOK 16 AKUNDEL Hosp.		d. STREET ADDRESS Route 2-Box 365	
3. NAME OF DECEASED (Type or print) HENRY VOGTMANN		4. DATE OF DEATH Month 8 Day 21 Year 1966	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5/13/10
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) GUARD		10b. KIND OF BUSINESS OR INDUSTRY USF & G	9. AGE (In years last birthday) 56 yrs
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME WILLIAM M. VOGTMANN		14. MOTHER'S MAIDEN NAME VALARIE ZENNOG	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO 212059002	
17. INFORMANT GERALDINE VOGTMANN RT. 2 PASADENA MD 21122		Address 21122	
18. CAUSE OF DEATH (Enter only one cause per part for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cancer disease 4344 DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (c) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH Just in	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day Year Hour o.m. _____ p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE E. Hubbard EXAMINER'S NAME (Type) E. Hubbard		22. DATE SIGNED 8/21/66	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 8/24/66	
23c. NAME OF CEMETERY OR CREMATORY LOUDON PARK CEMETERY		23d. LOCATION (City or Town) (County) (State) BALTIMORE, MARYLAND	
24. FUNERAL DIRECTOR HOWARD H. HUBBARD 4107 WILKENS AVE. 21229		25a. REC'D BY REGISTRAR DATE AUG 24 1966	
25b. REGISTRAR'S SIGNATURE Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

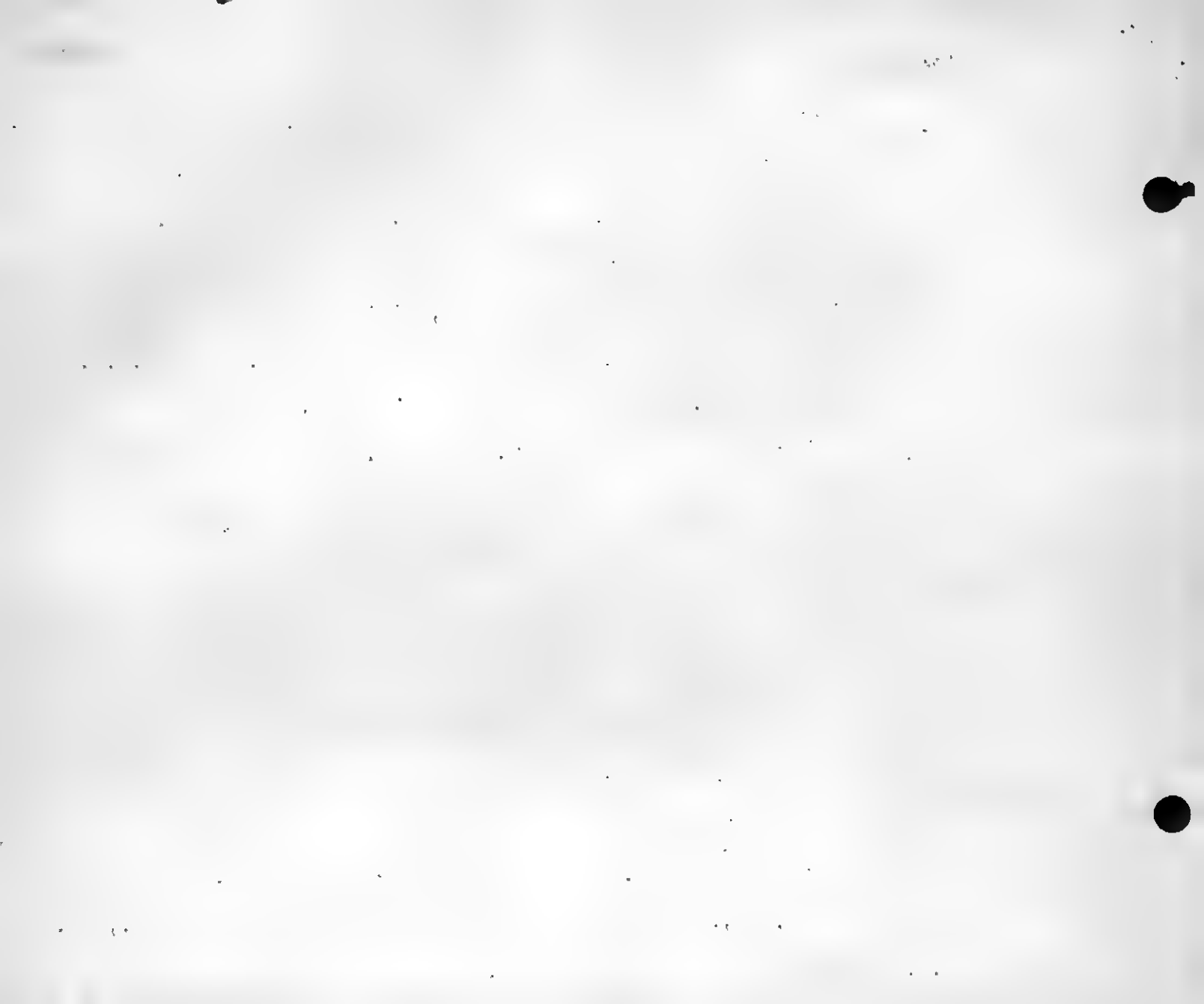
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AIS (4)
20M 1/65

22

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
10920 CERTIFICATE OF DEATH 10910											
1. PLACE OF DEATH a. COUNTY ANNE ARUNDEL MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE MARYLAND b. COUNTY ANNE ARUNDEL					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) GLEN BURNIE				c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) FERNOALE (Glen Burnie)				d. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) NORTH ARUNDEL HOSPITAL						d. STREET ADDRESS 212 S. HOLLINS FERRY RD.					
3. NAME OF DECEASED (Type or print) First Middle Last HELEN NAOMI WAGNER			4. DATE OF DEATH Month Day Year AUGUST 23 19 66			5. SEX FEMALE			6. COLOR OR RACE WHITE		
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH MAY 2, 1900			9. AGE (In years last birthday) 66 yrs.			10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE			10b. KIND OF BUSINESS OR INDUSTRY OWN HOME			11. BIRTHPLACE (County & State, or foreign country) ANNE ARUNDEL CO.			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME WILLIAM T. DOWNS						14. MOTHER'S MAIDEN NAME AMANDA V. CONNER					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO			16. SOCIAL SECURITY NO. NONE			17. INFORMANT MR. ALBERT H. WAGNER			Address SAME AS # 2		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) Myocardial Infarction Arterio-sclerotic Heart Disease									INTERVAL BETWEEN ONSET AND DEATH		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)									19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)								
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from 1963, 19, to 1966, that (I) (we) last saw the deceased alive on 8-10-1966, and that death occurred at 7:57 PM, from the causes and on the date stated above.											
22a. SIGNATURE Ignas Saulynas, M.D.						22b. DATE SIGNED			22c. PHYSICIAN'S NAME (Type) Ignas Saulynas, M.D.		
22d. ADDRESS 319 Old Annapolis Rd. Ferndale						22e. M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22f. DATE		
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL			23b. DATE THEREOF AUG. 27, 1966			23c. NAME OF CEMETERY OR CREMATORY FREINSHIP CEMETERY			23d. LOCATION (City, town or county) (State) ANNE ARUNDEL CO., MD.		
24. FUNERAL DIRECTOR R.V. SINGLETON						24b. ADDRESS GLEN BURNIE, MD.			25a. REC'D BY REGISTRAR DATE AUG 25 1966		
						25b. REGISTRAR'S SIGNATURE J Charles Judge					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 of 2. Page 2 of 2. Page 3 of 2. Page 4 of 2. Page 5 of 2. Page 6 of 2. Page 7 of 2. Page 8 of 2. Page 9 of 2. Page 10 of 2. Page 11 of 2. Page 12 of 2. Page 13 of 2. Page 14 of 2. Page 15 of 2. Page 16 of 2. Page 17 of 2. Page 18 of 2. Page 19 of 2. Page 20 of 2. Page 21 of 2. Page 22 of 2. Page 23 of 2. Page 24 of 2. Page 25 of 2. Page 26 of 2. Page 27 of 2. Page 28 of 2. Page 29 of 2. Page 30 of 2. Page 31 of 2. Page 32 of 2. Page 33 of 2. Page 34 of 2. Page 35 of 2. Page 36 of 2. Page 37 of 2. Page 38 of 2. Page 39 of 2. Page 40 of 2. Page 41 of 2. Page 42 of 2. Page 43 of 2. Page 44 of 2. Page 45 of 2. Page 46 of 2. Page 47 of 2. Page 48 of 2. Page 49 of 2. Page 50 of 2. Page 51 of 2. Page 52 of 2. Page 53 of 2. Page 54 of 2. Page 55 of 2. Page 56 of 2. Page 57 of 2. Page 58 of 2. Page 59 of 2. Page 60 of 2. Page 61 of 2. Page 62 of 2. Page 63 of 2. 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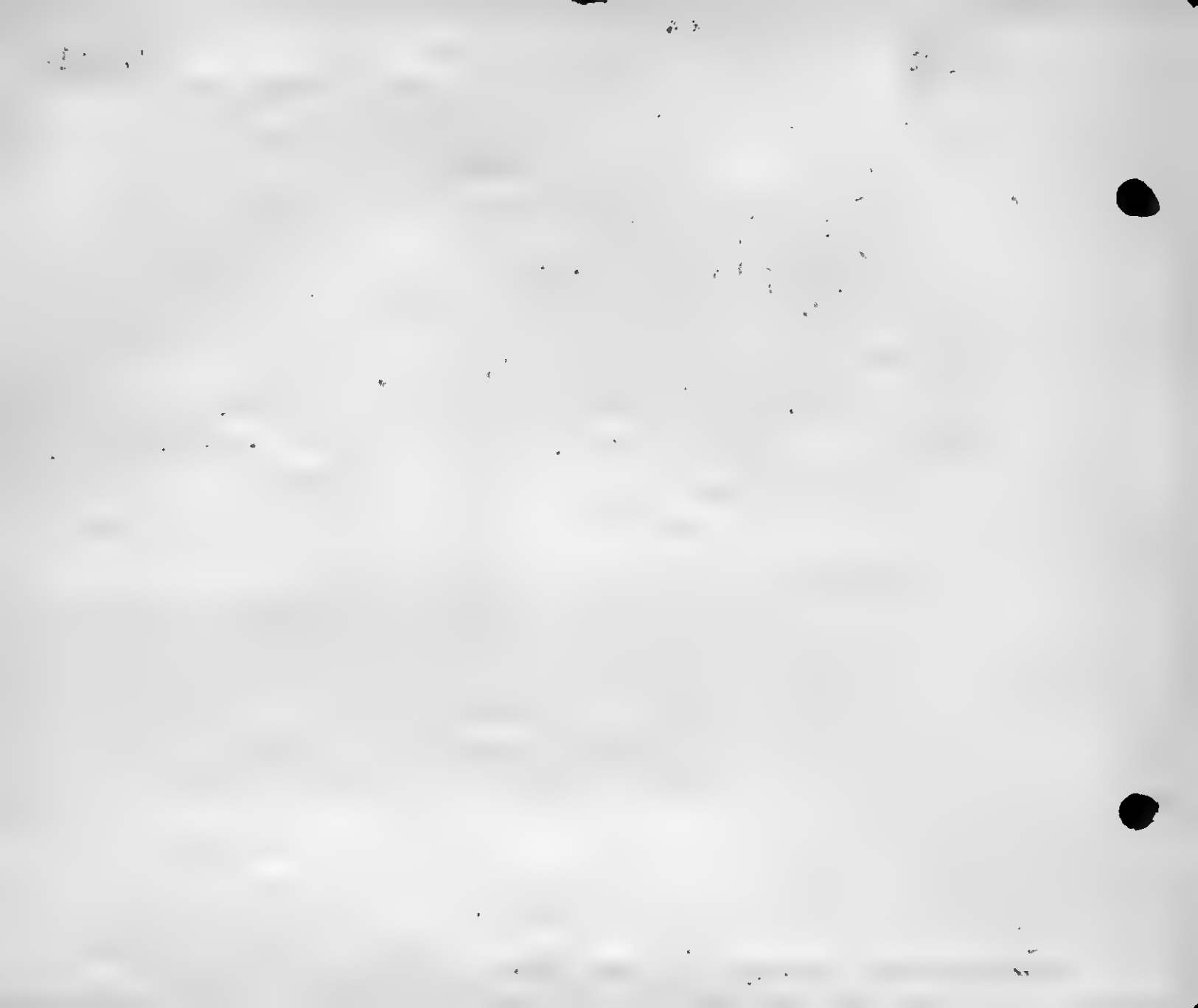
VR A15 (4)
15M 7 61

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

10922

10911

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>A.A.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not a hospital, give street address) <u>130 Best Gate Rd.</u>		d. STREET ADDRESS <u>130 Best Gate Rd.</u>	
3. NAME OF DECEASED (Type or print) <u>Joseph</u> <u>Wallace</u>		4. DATE OF DEATH <u>8</u> <u>19</u> <u>1966</u>	
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Col.</u>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>5/6/1914</u>	
9. AGE (In years last birthday) <u>52</u> yrs.		10. IF UNDER 1 YEAR: Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		11. BIRTHPLACE (County, State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Abraham Wallace</u>	
14. MOTHER'S MAIDEN NAME <u>Eda Creek</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? <u>No</u>	
16. SOCIAL SECURITY NO. <u>214052083</u>		17. INFORMANT <u>Abella Wallace - Annapolis, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cancer / prostate with metastases to various structures</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>14 mo</u> DUE TO (c)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>10-15-66</u> to <u>8-19-66</u> , that (I) (we) last saw the deceased alive on <u>5-14-66</u> , and that death occurred at <u>3 P</u> M, from the causes and on the date stated above.			
22a. SIGNATURE <u>J. Allen</u>		22b. DATE SIGNED <u>8-19-66</u>	
22c. PHYSICIAN'S NAME (Type) <u>J. ALLEN</u>		22d. ADDRESS <u>61 Catherine St</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>8/23/66</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>St. Marys</u>		23d. LOCATION (City, town or county) (State) <u>Annapolis, Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>William Reese, II</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>	
25b. REGISTRAR'S SIGNATURE <u>Anna, Md.</u>		DATE <u>AUG 22 1966</u>	



FOR STATE HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Give pages 1 and 2 with this State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MARYLAND STATE DEPARTMENT OF HEALTH

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10922

10912

1 PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie		c. LENGTH OF STAY IN 1b Minutes	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) North Arundel General Hospital		e. STREET ADDRESS Rt. #1 - Box 414	
3 NAME OF DECEASED (Type or print) First Middle Last ALEXANDER William WHITE		4. DATE OF DEATH Month Day Year 8 4 19 66	
5 SEX Male	6. COLOR OR RACE Colored	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-27-07
9 AGE (in years lost by day) 58 yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) State Roads	
11 BIRTHPLACE (State or foreign country) A.A. Co, Maryland		12 CITIZEN OF WHAT COUNTRY? U.S.A.	
13 FATHER'S NAME Arthur White		14. MOTHER'S MAIDEN NAME Carrie Watts	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO 220-05-2645	
17. INFORMANT Mrs Aileen White		Address Rt 1 Bx 414 Severna Park, Md	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) DUE TO Multiple traumatic injuries Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) Pedestrian struck by truck while working on State Road	
20c. TIME OF INJURY Month, Day, Year Hour o m 11:00 PM 8 4 19 66		20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office, bldg, etc.) State Road		20f. (City or town) (County) (State) Anne Arundel Md.	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>Rudiger Breitenecker</i> EXAMINER'S NAME (Type) RUDIGER BREITENECKER, M.D.		22. DATE SIGNED 8-5-66	
23a. BURIAL, CREMATION REMOVAL (Specify) Burial		23b. DATE THEREOF 8/8/66	
23c. NAME OF CEMETERY OR CREMATORY Carpenter Hill		23d. LOCATION (City or Town) (County) (State) Severna Pk A.A. Md	
24. FUNERAL DIRECTOR C.E. Hicks, III		ADDRESS Annapolis, Md	
25a. REC'D BY REGISTRAR AUG 10 1966		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal and return event within 72 hours after death.

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MAYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
10928		MEDICAL EXAMINER'S CERTIFICATE OF DEATH						10918			
1 PLACE OF DEATH a COUNTY <u>Anne Arundel</u> MARYLAND						2 USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a STATE <u>Maryland</u> b COUNTY <u>AA</u>					
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Winchester</u>				c LENGTH OF STAY IN 1b		c CITY OR TOWN (If outside of corporate limits, write RURAL and give nearest town) <u>Winchester</u>					
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Winchester Road</u>						d STREET ADDRESS <u>E. Winchester Rd</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) <u>DAVID Elwood Williams Jr</u>						4 DATE OF DEATH Month <u>8</u> Day <u>28</u> Year <u>1966</u>					
5 SEX <u>M</u>		6 COLOR OR RACE <u>W</u>		7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8 DATE OF BIRTH <u>4/22/93</u>		9 AGE (In years last birthday) yrs <u>73</u>		10 IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min <u> </u>	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Executive</u>				10b KIND OF BUSINESS OR INDUSTRY <u>Garment</u>				11 BIRTHPLACE (State or foreign country) <u>Brooklyn, N.Y.</u>		12 CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13 FATHER'S NAME <u>DAVID E. Williams</u>						14 MOTHER'S MAIDEN NAME <u>ELIZABETH STOKES</u>					
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>YES</u> <u>WW2</u>				16 SOCIAL SECURITY NO <u> </u>		17 INFORMANT <u>ANGELINE F. Williams</u> Address <u>#2</u>					
18 CAUSE OF DEATH (Enter only one cause per part for (a), (b), and (c))											
PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Coronary - Sudden</u>											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Hypertensive Cardiovascular Disease</u>											
(c) <u> </u>											
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (b) <u>none</u>											
19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.						20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <u>no injury</u>					
20c TIME OF INJURY Month, Day, Year Hour o.m. <u> </u> p.m. <u>19</u>				20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>		20f (City or town) (County) (State)			
21 I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <u>Charles H. Wirth M.D.</u>						CHIEF MEDICAL EXAMINER <input type="checkbox"/>					
EXAMINER'S NAME (Type) <u>Charles H. Wirth, M.D.</u>						ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					
						DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
						Address (Street, city, town, or county)					
23a BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>				23b DATE THEREOF <u>8-31-66</u>		23c NAME OF CEMETERY OR CREMATORY <u>ST. ANNE'S</u>				23d LOCATION (City or Town) (County) (State) <u>Annapolis MD.</u>	
24 FUNERAL DIRECTOR <u>John M. Taylor & Sons Annapolis, Md.</u>						25a REC'D BY REGISTRAR DATE <u>AUG 31 1966</u>		25b REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

CERTIFICATE OF DEATH

10924

10914

1. PLACE OF DEATH a. COUNTY ANNE ARUNDEL b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) FT. GEO. G. MEADE c. LENGTH OF STAY IN b. 12 HRS. d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) KIMBROUGH ARMY HOSPITAL		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MARYLAND b. COUNTY ANNE ARUNDEL c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) FT. GEO. G. MEADE d. STREET ADDRESS 1923-C REECE ROAD e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First RICKY Middle WILLIAMS Last WILLIAMS		4. DATE OF DEATH Month AUG Day 10 Year 1966	
5. SEX MALE	6. COLOR OR RACE CAUCASIAN	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH AUG 10 1966
9. AGE (In years last birthday) 0 yrs		10. IF UNDER 1 YEAR Months 0 Days 0	11. IF UNDER 24 HRS. Hours 12 Min. 48
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY N/A	
11. BIRTHPLACE (County & State, or foreign country) ANNE ARUNDEL, MD.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME FREDDIE WILLIAMS		14. MOTHER'S MAIDEN NAME JUDITH CALLAGHAN	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If yes give war or dates of service) N/A		16. SOCIAL SECURITY NO. N/A	
17. INFORMANT Judith Callaghan (mother)		Same #2	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIO-RESPIRATORY ARREST DUE TO (b) PREMATURITY Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)		INTERVAL BETWEEN ONSET AND DEATH 10 Minutes LIFE	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 1600 10 AUG 1966 , to 2100 10 AUG 1966 , that (I) (we) last saw the deceased alive on 10 AUG 1966 , and that death occurred at 2100 , from the causes and on the date stated above.			
22a. SIGNATURE <i>Fred Nomura</i>		22b. DATE SIGNED 10 Aug 66	
22c. PHYSICIAN'S NAME (Type) FRED NOMURA, CAPT, MC		22d. ADDRESS KIMBROUGH ARMY HOSP, FT GEO G MEADE, MD	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 8/13/66	23c. NAME OF CEMETERY OR CREMATORY Jefferson Memorial	23d. LOCATION (City, town or county) (State) Montevallo Alabama
24. FUNERAL DIRECTOR'S SIGNATURE <i>De Witt Donaldson</i>		25. REC'D BY REGISTRAR Charles Judge	
25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		DATE AUG 22 1966	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10925

CERTIFICATE OF DEATH

10915

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore City	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville		c. LENGTH OF STAY IN lb 22 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Crownsville State Hospital		d. STREET ADDRESS 502 N. Clinton St.	
3. NAME OF DECEASED (Type or print) 3-#32768 First Lillian Middle K. Wrede Last		4. DATE OF DEATH Month 8 Day 17 Year 19 66	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 10, 1886
9. AGE (In years last birthday) yrs. 80		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Benjamin F. Jones		14. MOTHER'S MAIDEN NAME Elizabeth Smith	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 213-05-2553	
17. INFORMANT Hospital Records		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: 334X IMMEDIATE CAUSE (a) Pneumonia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) Generalized, severe arteriosclerosis (Cerebro-vascular) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic Brain Syndrome with Psychotic Reaction			
19a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) -----	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. ----- 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) -----	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 7/25 , 19 66 , to 8/17 , 19 66 that (I) (we) last saw the deceased alive on 8/17 , 19 66 , and that death occurred at 2:05 AM , from causes and on the date stated above.			
22a. SIGNATURE <i>Lionel McHenry Happ</i>		22b. DATE SIGNED 8/17/66	
22c. PHYSICIAN'S NAME (Type) Lionel McHenry Happ, M. D.		22d. ADDRESS Crownsville State Hospital, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 8/20/66	23c. NAME OF CEMETERY OR CREMATORY Oaklawn Cem	23d. LOCATION (City or Town) (County) (State) Balto. Md.
24. FUNERAL DIRECTOR Chas E Evans & Son		25a. REC'D BY REGISTRAR DATE AUG 22 1966	
ADDRESS 8802 Hartford Rd		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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STATE OF NEW YORK

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CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY ANNE ARUNDEL MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE PENN b. COUNTY -	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ft George G. Meade		c. LENGTH OF STAY IN lb 2 Weeks	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Collingdale
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Building T-928		d. STREET ADDRESS 433 Westmont Drive	
3. NAME OF DECEASED (Type or print) First ROBERT Middle JAMES Last ZANE		4. DATE OF DEATH Month AUGUST Day 19 Year 19 66	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 22 APR 1927
9. AGE (In years last birthday) yrs. 39		IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Serviceman		10b. KIND OF BUSINESS OR INDUSTRY U.S. Army	11. BIRTHPLACE (County & State, or foreign country) Phila. Penn
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Aaron Zane	
14. MOTHER'S MAIDEN NAME Elizabeth Curry		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes 12/10/46-Present 211-16-0018	
16. SOCIAL SECURITY NO. 211-16-0018		17. INFORMANT Address Extracted from 201 File by S/Maj Akins, 28 Gen Hosp, Ft Geo G. Meade, Md	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Temp. Certificate pending completion of autopsy/examination DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Probable combined effects of Ethanol and Secobarbital DUE TO (c) Secobarbital		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that Robert James Zane Robert James Zane deceased 19 19 19 Aug , 19 66 66 that death occurred at 9:05 a.m. from causes and on the date stated above.			
22a. SIGNATURE Frank Urso M.O.		22b. DATE SIGNED 19 Aug 1966	
22c. PHYSICIAN'S NAME (Type) FRANK URSO, CAPT, MC		22d. ADDRESS Pathologist, 1st Army Lab, Ft Geo G. Meade, Md	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF August 24, 66	23c. NAME OF CEMETERY OR CREMATORY Beverly National Cem	23d. LOCATION (City or Town) (County) (State) BEVERLY, NEW JERSEY
24. FUNERAL DIRECTOR Harold W. Lavelle, Inc		25a. REC'D BY REGISTRAR SEP 7 1966	
25b. REGISTRAR'S SIGNATURE Charles Judge			

